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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND, HOWARD MCDOUGALL, *et al.*,
Petitioners,

v.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Employee Retirement Income Security Act ("ERISA") provides that "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument." ERISA § 402(a)(1), 29 U.S.C. § 1102 (a)(1). ERISA also states that every plan shall have a "plan administrator" who will discharge his duties "in accordance with the documents and instruments governing the plan. . . ." ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D). Finally, ERISA provides that a plan fiduciary may bring a civil action "to enforce . . . the terms of the plan." ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

1. Whether the written terms of an ERISA employee benefit plan may be modified by means of either oral representations or by conduct inconsistent with the terms of the plan?

LIST OF PARTIES

The Petitioners herein consist of the Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States") and Howard McDougall, Robert J. Baker, Arthur H. Bunte, Jr., R. V. Pulliam, Sr., and R. Jerry Cook (who are designated fiduciaries of Central States, and Members of its Board of Trustees).*

Pathology Laboratories of Arkansas, P.A., the Appellee below and the Respondent in this Petition, is the only other party.

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* Marion M. Winstead, Robert C. Sansone and Howard Leu originally joined as Plaintiffs in this case, but have since completed their terms as Central States Trustees.

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PETITION FOR A WRIT OF CERTIORARI

Central States and its fiduciaries named as Petitioners herein respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit is reported at 71 F.3d 1251 and is set forth at Appendix ("App.") 1A. The oral ruling of the district court entered at the conclusion of trial is unreported, but is set forth at App. 10a. The opinion of the United States District Court for the Northern District of Illinois ruling on a motion for partial summary judgment in this case is reported at 1992 U.S. Dist. LEXIS 9319, 1992 WL 396294, and is set forth at App. 18a.

JURISDICTION

The judgment of the court of appeals was entered on December 1, 1995. Jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

29 U.S.C. § 1102(a). Establishment of Plan.

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained *pursuant to a written instrument.* Such instrument shall provide for one or more *named fiduciaries* who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term *"named fiduciary" means a fiduciary who is named in the plan instrument,* or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

(emphasis added).

29 U.S.C. § 1104(a)(1)(D). Fiduciary Duties.

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

* * * *

(D) *in accordance with the documents and instruments governing the plan* insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

(emphasis added).

29 U.S.C. § 1132(a)(3). Civil Enforcement.

(a) Persons empowered to bring a civil action

A civil action may be brought—

* * * *

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter *or the terms of the plan;*

(emphasis added).

STATEMENT OF THE CASE

Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States" or the "Central States" or the "Central States Health and Welfare Fund") is a multiemployer employee welfare benefit plan within the meaning of ERISA, 29 U.S.C. § 1002(2). The trustees of Central States are collectively the "plan sponsor" within the meaning of 29 U.S.C. § 1002(16)(B). The Central States Health and Welfare Fund is one of the largest multiemployer employee benefit plans in the United States, and provides health coverage to hundreds of thousands of employees (most of whom are employed in the trucking industry) and their dependent family members. *Central Transport v. Central States*, 472 U.S. 559, 562, n.1, 105 S.Ct. 2833, 2836, n.1, *reh'g denied* (1985).

Jurisdiction in the district court was based upon 29 U.S.C. § 1132(a)(3) & (e). That is, Central States' plan fiduciaries brought this action in federal district court "to enforce . . . *the terms of the* [*Central States*] *plan*," within the meaning of 29 U.S.C. § 1132(a)(3) (emphasis added).

Central States' Plan Document contains a term requiring that a participant "*receive treatment*" from a health

care provider as a condition for coverage of the provider's charges. (App., pp. 2a-3a; emphasis added.) The Central States Plan also states that any "excess" payments made by Central States—*i.e.*, in excess of the coverage terms of the plan—are subject to a refund. (App., pp. 7a-8a.) This case concerns the circumstances under which these written plan terms may be modified by means of oral representations, or conduct inconsistent with the terms of the plan.

Pathology Laboratories of Arkansas, P.A. ("Pathology Laboratories") consists of a group of pathologists practicing in Little Rock, Arkansas. The pathologists charge individual hospital patients—including those covered by Central States—for each clinical laboratory test. (App., p. 2a.) However, the pathologists do not perform the tests; nor do they review the test results. Rather, the tests are conducted on automated equipment by a hospital in Little Rock, Arkansas (the Baptist Medical System). (App., pp. 2a-3a.)[1] The hospital also charges individual patients for these same tests. Pathology Laboratories claims a right to bill the individual hospital patients for work performed by Pathology Laboratories in "setting up test protocols, calibrating the equipment" and other general administrative services performed for the hospital laboratory. (App., p. 2a.) Pathology Laboratories calls these charges the "*professional component*" of each individual clinical laboratory test. (*Id.*)

For the most part, prior to November 1991, Central States paid the charges made by Pathology Laboratories for the tests conducted by the hospital (while also paying the hospitals' separate charges for the same tests). (App., p. 3a.) In November 1991, Central States made a preliminary determination on the staff level that these charges should not be covered; that staff level determination was

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[1] This case concerns clinical laboratory pathology only, and not anatomic or surgical pathology in which the pathologists perform an actual, hands-on examination of a patient's tissue sample.

subject to review by the Central States Board of Trustees. (App., p. 2a, pp. 21a-22a.) Consequently, in November 1992, the Central States Board of Trustees reviewed the Pathology Laboratories' practice of charging a separate "professional component" for each individual test charged by the hospital. Pathology Laboratories submitted its explanation of the "professional component" charges to the Central States Board, and the Central States Board considered the issue in light of the scope of coverage provided by the terms of the Central States plan document. (App., p. 22a.)

As indicated in the opinion of the U.S. Court of Appeals for the Seventh Circuit in this case, the express terms of the Central States plan document excluded coverage for Pathology Laboratories' "professional component" charges. The court of appeals' opinion states:

> Article 4.11 of [Central States'] Plan Document . . . restricts payment to the expenses of a person who "*receives treatment*". *The professional component fee does not signify that a person received any treatment by a pathologist* and therefore, the Fund concluded, is not compensable.

(App., pp. 2a-3a; emphasis added.) Accordingly, the Central States Board of Trustees decided that Pathology Laboratories' professional component charges were beyond the scope of coverage of the Central States plan.

Pathology Laboratories then challenged the decision of the Central States Board in U.S. District Court, and sought

> a declaration that the Plan Document permits payment of professional component fees. [The district court] granted summary judgment to the Fund on [this issue]. 1994 U.S. Dist. Lexis 9319 (N.D. Ill.)

(App., p. 3a.)

The district court's opinion on this coverage issue held that the terms of the Central States Plan Document un-

ambiguously excluded the pathologists' professional component charge:

> *[W]e find that the terms of the Plan are unambiguous, and that the Trustees' application of those terms to the professional component charges is in accord with the plain meaning of the terms of the Plan.*
>
> a. *Section 4.11 is Unambiguous.*
>
> Section 4.11 states:
>
> > Except as otherwise provided herein, a claim for Basic Benefits or Major Medical Expense Benefits shall not be paid unless the Covered Individual is ill, injured, pregnant or an organ donation, *and receives treatment*, compensable under this plan, related to the injury, pregnancy or organ donation.
>
> There is nothing ambiguous about this provision. It states quite clearly that a claim will be paid only if the "Covered Individual . . . *receives treatment* . . ." Pathology Laboratories cannot create an ambiguity by interpreting the phrase "receives treatment" to include "setting parameters for tests results" and "reviewing qualify assurance data." This is not "treatment" as the word "treatment" is understood in "an ordinary and popular sense." We will not allow Pathology Laboratories to create an ambiguity where none exists.

(App., p. 28a; emphasis added; citations omitted.) As noted in the Court of Appeals' opinion in this case, Pathology Laboratories did not appeal this ruling by the district court concerning the scope of coverage under the express terms of the Central States Plan Document, and the plain meaning of the plan language. (App., p. 3a.)

Instead the issue before the court of appeals concerned Central States' claim for a *refund* of certain amounts paid to Pathology Laboratories for the professional component prior to Central States' decision to refuse to pay those

charges.[2] As the Court of Appeals' opinion explains, Central States' Plan Document contained a provision requiring a refund of any "excess payments" made to participants, beneficiaries, or health care service providers. (App., pp. 7a-8a, p. 47a.) Central States argued that since there was unambiguous language in the Central States Plan Document excluding coverage for charges of the type submitted by Pathology Laboratories (as held by the district court), these charges were clearly "excess payments". Any such "excess payments" must, in turn, be refunded to Central States pursuant to the refund provision in the Central States Plan. (App., pp. 7a-8a.)

The court of appeals rejected Central States' argument. The court held that Central States (or, more accurately, the Central States claims adjustors who originally made the payments to Pathology Laboratories) had "interpreted" the Central States Plan Document to cover the professional component charges. In the view of the court of appeals, Central States (through its Board of Trustees) had later changed this "interpretation", and denied coverage for the professional component charge:

> [I]t does not follow that a welfare benefit fund acquires the right to change the *interpretation* of its plan after [health care] providers *have relied to their detriment*. A change in *interpretation* makes it hard to call the earlier payments "excess."

(App., p. 8a; emphasis added.) Therefore, the Court of Appeals held that Central States' prior payments to Pathology Laboratories effectively raised an estoppel which barred Central States from later claiming that the payments were in "excess" of those provided under the express terms of the Central States Plan Document. (App., pp. 8a-9a.) Accordingly, the Court of Appeals affirmed the decision of the district court denying Central States' refund claim.

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[2] In the district court, the coverage question was decided by Judge Duff. The case was then transferred to Judge Bucklo and Judge Bucklo decided the refund issue.

The district court had also held that Central States' claims payment staff knew or should have known that Pathology Laboratories was *not* in fact providing "treatment" to the individual Central States participants which would warrant coverage under the Central States Plan. (App., p. 12a.) In view of this knowledge imputed to Central States' claims payment staff, the district court precluded Central States from recovering a refund of the prior payments under a traditional common law theory of "mistaken" payment. (App., pp. 12a-13a.) The Seventh Circuit affirmed this finding. (App., pp. 7a-13a.) For purposes of this Petition, Central States does not challenge this ruling concerning the subjective state of mind of the Central States' claims adjustors. Rather, this Petition focuses solely upon the Court of Appeals' holding that Central States was not entitled to a refund because the prior payments to Pathology Laboratories could not be deemed to be in "excess" of the coverage allowed under the objective meaning of the written terms of the Central States Plan Document.

REASONS FOR GRANTING THE WRIT

I. INTRODUCTION AND SUMMARY.

This case presents the recurring problem of whether and to what extent the federal courts may "modify" or "interpret" the terms of an ERISA plan document, based upon words or conduct inconsistent with the written plan terms.

Central States' plan document requires a refund of any payments made by Central States "in excess" of the coverage provided under the Central States Plan Document. (App., pp. 7a-8a.) The opinion of the Seventh Circuit U.S. Court of Appeals in this case acknowledged that the Central States Plan Document requires a health care service provider to perform a "treatment" for a Central States participant before Central States will cover the health care provider's charges. (App., pp. 2a-3a.) The

court of appeals also recognized that Pathology Laboratories had not satisfied this *sine qua non* for coverage, and, therefore, Pathology Laboratories was not entitled to coverage under the terms of the Plan Document. (*Id.*)

However, the court of appeals noted that prior to the decision by the Central States Board of Trustees to deny coverage for Pathology Laboratories' "professional component" charges, Central States' claims payment staff had *paid* the professional component charges. (App., pp. 6a-7a.) The court of appeals held that this earlier decision by Central States' claims adjustors to pay the "professional component" charges constituted an "interpretation" of the Central States Plan Document. (App., p. 7a.) Further, in the court of appeals' view, Pathology Laboratories "relied to [its] detriment" on this prior "interpretation" of the Central States Plan Document. (App., p. 8a.) From this the court of appeals concluded that Central States (or its fiduciaries/Board of Trustees) could not change the prior "interpretation" (in favor of coverage of the professional component charges) and substitute a new "interpretation" (no coverage for these charges). (*Id.*) Due to what it viewed as a change in "interpretation" of the coverage terms of the Central States Document, the court of appeals held that the prior payments to Pathology Laboratories did not constitute payments in "excess" of allowed coverage for the purposes of the refund provision in the Central States Plan. (*Id.*)

In contrast to the approach taken by the Seventh Circuit in this case, most of the other federal circuits hold that the written terms of an ERISA plan cannot be modified by means of oral representations or conduct inconsistent with the plan language. (*See* p. 14, *infra.*) The Seventh Circuit professed to be using estoppel principles ("detrimental reliance") to "interpret" the Plan Document, but most of the other circuits only allow an "interpretation" of the plan if the written plan terms at issue are *ambiguous*. (*See*, p. 15, *infra.*) The Seventh Circuit disregarded the distinction between plan "interpreta-

tion," and plan "modification" developed by other circuits. (*See* p. 15, *infra.*) The Seventh Circuit's application of common law principles of estoppel to overturn the terms of an ERISA plan conflicts not only with holdings in the other circuits, but also with prior decisions by this Court.

Further, as an assignee of the employee/participants of the Central States Plan, Pathology Laboratories is itself a statutorily defined beneficiary of the Central States Plan (and thus a party to that Plan). (*See* p. 19, *infra.*) Employee/participants in benefit plans are routinely told by the federal courts that the language of their ERISA Plan Document cannot be modified by means of oral or other informal representations that contradict the plan terms. (*See*, p. 19, *infra.*) This same rule should apply to Pathology Laboratories—who is, like each of the employee/participants from whom it took an assignment, a party to (*i.e.*, a beneficiary of) the Central States. The employee/participants are the primary persons who are supposed to be protected by ERISA. It is senseless to hold the employee/participants to a strict reading of the ERISA plan documents (even when outright lies are told to them concerning the nature of their benefits), but to modify the plan document on an *ad hoc* basis for the sake of a health care service provider.

Issues concerning the use of traditional common law doctrines to modify or interpret an ERISA plan document have been vexing the federal court system for some time. It is now time for this Court to act. This case represents an excellent vehicle through which the Court might choose to clarify this issue. The Central States Document in this case was expressly held by the district court in this case to be "*unambiguous*" in excluding coverage of the charges at issue here. (App. p. 2a; emphasis added.) This holding that the plan was clear on its face as relates to the coverage issue was not appealed by Pathology Laboratories. (App., p. 3a.) Therefore, the Court need not struggle with whether particular language is unambiguous. That

issue has already been definitively concluded for purposes of this case. This Court may therefore proceed directly to a consideration of the circumstances, if any, under which unambiguous plan language may be modified or "interpreted" through inconsistent oral representations or conduct.

II. THE SEVENTH CIRCUIT'S OPINION CONFLICTS WITH THE CASES IN OTHER CIRCUITS HOLDING THAT THE SCOPE OF COVERAGE UNDER AN ERISA PLAN MUST BE CONTROLLED BY THE LANGUAGE OF THE PLAN DOCUMENT.

ERISA provides that a fiduciary may bring an action "to *enforce the . . . terms of* [*the ERISA benefit*] *plan.*" 29 U.S.C. § 1132(a)(3) (emphasis added). As noted, in this action Central States (or more accurately, its Trustees/fiduciaries) sought to enforce the Central States plan terms requiring receipt of medical "treatment" from a health care provider as a condition for covering the provider's charges. The Central States fiduciaries were also seeking to enforce the plan term requiring a *refund* of any payments made in "excess" of the allowed coverage.

In deciding this plan enforcement issue, the court of appeals below did not adhere to the language of the Central States Plan Document. The court of appeals' opinion does note that "*the professional component fee does not signify that the patient received any treatment by a pathologist*"; the opinion also acknowledges that the receipt of such "treatment" is an express requirement for coverage under the Central States Plan Document. (App., pp. 2a-3a; emphasis added.) However, in analyzing the *refund* issue, the court of appeals' opinion disregards this provision in the Plan Document requiring actual "treatment" by the health care provider before Central States' *coverage* can be allowed for his charges. This coverage term is crucial to the refund question, because any payment made by Central States in "excess" of the required coverage is subject to a refund. (App., pp. 7a-8a.) As the

court of appeals noted, the refund provision in Central States' Plan Document states:

> *11.04 Recovery of Excess Payments*
>
> Whenever this Plan has made benefit *payments exceeding the amount of benefits payable under the terms of this plan, the Fund shall have the right to recover the excess payments from any responsible person or entity,* including the right to deduct the amount of excess payments from any subsequent payable benefits.

(App., p. 47a; *see also* App., pp. 7a-8a; emphasis added.)

The court of appeals addressed the underlying coverage issue by reasoning that Central States had simply changed its "interpretation" of the applicable coverage terms:

> [I]t does not follow that a welfare benefit fund acquires the right to change the *interpretation* of its plan after [health care] providers *have relied to their detriment.* A change in *interpretation* makes it hard to call the earlier payments "excess."

(App., p. 8a; emphasis added.) Thus the court of appeals reasoned that Central States' claims payment staff had known all along that Pathology Laboratories was not "treating" the Central States participants in any meaningful sense, but had, for some reason, nevertheless decided to extend coverage to Pathology Laboratories.[3] In the

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[3] This Petition does not seek review of the court of appeals' decision to affirm the district court's ruling concerning the subjective state of mind of Central States' claims payment staff. (App., p. 7a.) But the court of appeals' opinion states that Central States' staff had to have known that Pathology Laboratories was not providing patient-specific treatment because Central States' medical consultant had issued an opinion to this effect. (App., p. 7a.) This fails to account for the fact that the consultant's opinion was not issued until March 1989, and that Central States began paying the professional component charges in 1986. (App., p. 3a.) Pursuant to a stipulation relating to damages, if Central States showed a right to a refund in *any* amount (or for any period), then Pathology Laboratories was liable for a total of $30,000. (App., p. 62a.) Moreover, the court of appeals' opinion overloks the fact

view of the court of appeals, the Central States Board of Trustees at a later point articulated a "*change in policy*" concerning the scope of coverage under the Central States Plan. (App., p. 8a.) According to the court of appeals' opinion, this "change in policy" or "reinterpretation" of the Central States Plan Document was sufficient to deny Pathology Laboratories' claims for coverage, but the "policy" change could not be applied "retroactively". On this basis, the court of appeals rejected Central States' claim for a refund. (App., p. 8a.) Thus, for the court of appeals, the question of what was covered, or not covered, under the Central States Plan had simply changed.

But the *language* in the Central States Plan Document did not change. The court of appeals' opinion acknowledged that (1) the Central States Plan required Pathology Laboratories to provide a "treatment" to the individual Central States members as a condition of coverage, and (2) that the disputed "professional component" charges "do not signify that a person received any treatment by a pathologist." (App., pp. 2a-3a.) Further, the district court had ruled that Central States' Plan Document (specifically Section 4.11) was "*unambiguous*" as applied to the pathologists' professional component charges, and that those charges were clearly excluded from coverage. (App., p. 28a.) Pathology Laboratories did not appeal this rul-

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that as early as 1985, Central States had published a claims manual stating (albeit *mistakenly*) that the professional component charges were for the pathologists' work in *"taking and interpreting"* the tests; as it turns out that wasn't true, but this undisputed written evidence showed that that is what Central States' staff believed. (Defendants' Trial Ex. 3, reproduced at App., p. 51a; emphasis added.) The court of appeals' opinion also states that Central States should not have believed that the pathologists performed a treatment or service with respect to each test because the *per test* charges were so low ($2-$5 per test). (App., p. 2a.) This reasoning overlooks the undisputed evidence showing the way in which the per test charges add up so quickly—totalling thousands of dollars for some patients during each of their hospital stays. (Plaintiff's Trial Ex. 49, reproduced at App., p. 54a.)

ing by the district court denying coverage for the professional component charges. (App., p. 3a.)

The holding of the U.S. Court of Appeals for the Seventh Circuit in this case—that an ERISA plan can change the scope of coverage by giving different "interpretations" to *unambiguous plan language*—is squarely at odds with cases decided in most other federal circuits. *Lake v. Metropolitan Life Ins.*, 73 F.3d 1372 (6th Cir. 1996) ("courts must give effect to the unambiguous terms of ERISA plans"); *Cinelli v. Security Pacific Corp.*, 61 F.3d 1437, 1444 (9th Cir. 1995) ("[b]ecause the plan contains no ambiguity . . . extrinsic evidence may not be used to alter the written terms of the plan"); *In re Unisys Corp. Retiree Medical Benefit ERISA Litigation*, 58 F.3d 896, 902 (3rd Cir. 1995) ("[t]he written terms of the plan documents control . . ."); *Averhart v. US West Management Pension Plan*, 46 F.3d 1480, 1485 (10th Cir. 1994), *reh'g denied* ("ERISA's express requirement that the written terms of a benefit plan shall govern forecloses the argument that Congress intended for ERISA to incorporate state law notions of promissory estoppel."); *Slice v. Sons of Norway*, 34 F.3d 630, 634 (8th Cir. 1994) ("[w]hen the alleged misrepresentations flatly contradict the unambiguous language of the plan, an estoppel is not available."); *Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341, 1347 (11th Cir. 1994) ("estoppel is not available . . . when the written plan is unambiguous"); *Singer v. Black & Decker Corporation*, 964 F.2d 1449, 1453-54 (4th Cir. 1992) ("ERISA demands adherence to the written terms of an employee benefit plan"); *Bellino v. Schulmberger Technologies, Inc.*, 944 F.2d 26, 32 (1st Cir. 1991) ("Basic contract and trust principles preclude federal courts from considering extrinsic evidence where the ERISA terms in question are unambiguous").

In this case the Seventh Circuit stated that it was using principles of estoppel (detrimental reliance) to conclude that the Central States Plan Document had simply been

given different "interpretations" at different times. The Seventh Circuit's opinion states: "[I]t does not follow that a welfare benefit fund acquires the right to change the *interpretation* of its plan after providers of services have *relied to their detriment.*" (App., p. 8a; emphasis added).[4] But this analysis disregards the important distinction that has developed in the other circuits between the "modification" as opposed to the "interpretation" of an ERISA Plan Document. The 11th Circuit has explained the distinction as follows:

> We have held that while "equitable estoppel is not available to plaintiffs in cases involving oral amendments to or modifications of employee benefit plans governed by ERISA because ERISA specifically addresses those issues," *we may apply equitable estoppel when the representations were interpretations not modifications, of the plan.* For a representation to be an *interpretation* of a plan, the relevant provisions of the plan must be *ambiguous*, that is to say, "reasonable persons could disagree as to [the provisions'] meaning and effect."

Novak v. Irwin Yacht Club and Marine Corp., 986 F.2d 468, 472 (11th Cir. 1993) (emphasis added; citations omitted). *See also Slice, supra*, 34 F.3d at 634 [8th Cir. embraces distinction between *interpretation* of an ambiguous plan (allowed) and *modification* of an unambiguous plan (disallowed)].

The Seventh Circuit's opinion in this case pays no heed to this distinction. The opinion applies "detrimental re-

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[4] Nowhere in the district court opinion or in the court of appeals' opinion, or in the record of this case, was there any evidence of detrimental reliance by Pathology Laboratories. In performing its "professional component" services, Pathology Laboratories was performing administrative services for the hospital as a whole, not performing "treatments" for individual Central States participants. (App., pp. 2a-3a.) Pathology Laboratories could not have withheld "treatment" to individual patients—such as those covered by Central States—even if it had wanted to.

liance" principles to "interpret" plan language which is only amenable to one reading when applied to these facts.[5] This is an "interpretation" in name only, and conflicts with the scope of legitimate ERISA plan interpretation articulated by several other cricuits. In short, the Seventh Circuit's opinion in this case endorses judicial "interpretation" of written ERISA plan documents, unfettered by consideration of the actual plan language.

III. THE SPLIT IN THE CIRCUITS IS RECURRING AND CONCERNS AN IMPORTANT ISSUE OF ERISA PLAN INTERPRETATION.

This case is not the first occasion on which the Seventh Circuit has split from the other circuits in holding that the written terms of an ERISA plan may be altered by means of estoppel, conduct or other representations short of a written plan amendment. *In Black v. TIC Investment Corp.*, 900 F.2d 112 (7th Cir. 1990), the Seventh Circuit held that estoppel could be used to modify the written terms of an ERISA plan. The Seventh Circuit noted in *Black* that the Fourth, Tenth and Eleventh Circuits hold a contrary view. 900 F.2d at 114-15. The commentary has also noted this recurring split in the circuit court authorities. *See, e.g.*, Comment, *Estoppel Claims Against ERISA Employee Benefit Plans*, 25 U.C. Davis L. Rev. 487, 491 ("The federal courts are divided on whether they may apply federal common law estoppel against ERISA plans."); Leslie L. Wellman & Shari J. Clark, *An Overview of Pension Benefit and Fiduciary Litigation under ERISA*, 26 Willamette L. Rev. 665, 692 (1990) (remarking that Ninth, Tenth and Eleventh Circuits do not allow estoppel recovery).

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[5] This is underscored by the court of appeals' discussion of the coverage issue (*i.e.*, the Central States Plan Document requires medical provider to give a "treatment", App., pp. 2a-3a). In addition, the district court expressly found the plan to be *unambiguous*, and this ruling was not appealed by Pathology Laboratories. (App., p. 28a.)

Central States covers a broad geographic area, and its participants are located throughout most of the United States. Consequently, issues concerning the scope of coverage under Central States Plan Document are routinely determined in a number of the federal circuits. *See, e.g., Buttram v. Central States,* —— F.3d ——, 1996 WL 65729 (8th Cir. 1966); *Freeman v. Central States,* 32 F.3d 90 (4th Cir. 1994); *Exbom v. Central States,* 900 F.2d 1138 (7th Cir. 1990). Whether the Central States Plan Document is going to be applied in accordance with its terms should not depend upon the forum in which the action is brought. This unpredictability is particularly vexing to Central States and other ERISA plans (and their participants and beneficiaries) that have a multi-state presence. The time is now ripe for the court to address this problem, which has been developing in the federal system for several years, and relates to a significant question arising under ERISA.

IV. THE SEVENTH CIRCUIT'S OPINION CONFLICTS WITH DECISIONS OF THIS COURT HOLDING THAT ESTOPPEL, DETRIMENTAL RELIANCE AND OTHER COMMON LAW THEORIES SHOULD NOT THWART FEDERAL STATUTES.

" '[R]ules of estoppel will not be permitted to thwart the purposes of statutes of the United States.' " *Kaiser Steel Corporation v. Mullens,* 455 U.S. 72, 82, 102 S.Ct. 851, 859 (1982), *quoting Sola Electric Co. v. Jefferson Electric Co.,* 317 U.S. 173, 176, 63 S.Ct. 172, 174, 87 L.Ed. 165 (1942). *See also Peacock v. Thomas,* —— S. Ct. —— 1996 WL 71099 (Feb. 21, 1996) ("piercing the corporate veil" claims are not cognizable under ERISA, absent allegations of "a violation of an ERISA provision *or terms of the plan*") (emphasis added); *Mertens v. Hewitt Associates,* 508 U.S. 248, 113 S.Ct. 2063, 2070 (1993) ("The authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute.") (citation omitted).

ERISA expressly requires that any employee benefit plan be "established and maintained pursuant to *written instrument.*" 29 U.S.C. § 1102(a)(1) (emphasis added). This "written instrument" must be subject to a formal "procedure for amending such plan." 29 U.S.C. § 1102 (b)(3) Further, the plan sponsor or fiduciaries (in this case, the Central States Trustees) are charged with administering the plan "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104. Finally, the enforcement provisions of ERISA, under which this action was initiated, state that plan fiduciaries may bring an action in federal court "*to enforce . . . the terms of the plan.*" 29 U.S.C. § 1132(a)(3)(B)(ii) (emphasis added). Requiring enforcement of the plan in accordance with its express terms furthers the ERISA policy goal of requiring that employee benefits be fixed and readily ascertainable. Conversely, deviation from the plan terms undermines the actuarial assumptions on which the plan has based its benefit levels; this, in turn, will erode the financial stability of the benefit plans—thereby frustrating another important policy goal of ERISA.[6]

Even the cases and commentary favoring the use of estoppel and other informal plan modifications have acknowledged that there are special reasons to hold fast to the plan language in the case of "funded" plans (such as Central States), as opposed to unfunded plans. *See* Comment, *Estoppel Claims Against ERISA Employee Benefit Plans, 25 U. C. Davis L. Rev.* 487, 550 (1992) ("Estoppel Comment"). "*Funded*" plans rely upon a fixed asset base (frequently funded by means of contractually specified contributions from numerous employers, as in the case of Central States). "*Unfunded*" plans simply represent the commitment of an employer to provide defined benefits directly out of the employer's pocket, without the mediation of a "fund" (such as Central States), and without regard to the cost of the benefits.

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[6] Congress set forth its purpose in ERISA § 2(a), 29 U.S.C. § 1001(a).

See Central States v. Central Transport, supra, 459 U.S. 559. Therefore, Central States and other funded plans have limited resources. These funded plans require the certainty provided by coverage terms etched in stone in order to secure their actuarial soundness and financial integrity. Estoppel Comment, 25 *U. C. Davis L. Rev.* at 550.

Faithful application of the plan language may occasionally produce results that seem harsh in individual cases. However, this is the mechanism which Congress chose in ERISA to assure comprehensive (rather than *ad hoc*) protection for employees and for the benefit plans on which they rely. As the Fifth Circuit has observed:

> [The Plaintiff] presents us with a sympathetic, estoppel-based argument for fashioning federal common law that would prevent employers and union officials from consoling displaced employees like [the Plaintiff] with empty oral assurances about rights to pension benefits . . . *The problem, however, is one for Congress and not this court to resolve, for we are bound by ERISA's emphatic preference for written agreements.*

Degan v. Ford Motor Co., 869 F.2d 889, 895 (5th Cir. 1989) (emphasis added).

In this case Pathology Laboratories took assignments of benefits from various Central States participants. (Plaintiffs' Trial Ex. 52.) On the basis of these assignments, Pathology Laboratories proceeded to present its position on the issue of coverage under the Central States Plan Document to the Central States Board of Trustees, and then to a federal district court. (App., p. 3a, p. 22a.) Therefore, Pathology Laboratories was a beneficiary under the Central States Plan, and a party to that Plan, just as surely as the employee participants from whom Pathology Laboratories took its assignments. *Kennedy v. Connecticut General Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir. 1991) (in 29 U.S.C. § 1002(8),

ERISA defines a "beneficiary" of a plan as one who has been designated by a participant to receive benefits due to the participant under the plan).

If the statutory text and policy goals of ERISA require adherence to the written plan even when an employee/participant receives an oral representation from the plan sponsor contradicting the plain meaning of the plan document, the same result should follow with even greater force in the case of a plan beneficiary/health care provider (such as Pathology Laboratories). Both the employee/plan participant and the health care provider/plan beneficiary are statutorily defined parties to the ERISA plan. Moreover, it would be a disturbing anomaly to show more solicitude under ERISA, and more willingness to bend the terms of the written plan, in the interests of a health care provider, than in the interests of the employee/participants. Although both the health care provider and the employee/participant may be parties to the ERISA plan (and in fact in this case they are), the employee/participant is the primary person falling within the intended remedial and protective scope of ERISA.

The Seventh Circuit placed a common law gloss of detrimental reliance and estoppel principles upon ERISA. In this case, these principles are inconsistent with the text and underlying purposes of the statute. This result, in turn, conflicts with the prior decisions of this Court. *See, e.g., Mertens, supra,* 113 S. Ct. at 2070; *Kaiser Steel, supra,* 455 U.S. at 82.

CONCLUSION

For these reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX

APPENDIX

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 95-2171

CENTRAL STATES SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND, *et al.*,
Plaintiffs-Appellants,

v.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.,
Defendant-Appellee.

Appeal from the United States District Court for the
Northern District of Illinois, Eastern Division
No. 92 C 4141—ELAINE E. BUCKLO, *Judge*

Argued October 25, 1995—Decided December 1, 1995

Before BAUER, EASTERBROOK, and EVANS, *Circuit Judges.*

EASTERBROOK, *Circuit Judge.* The Baptist Medical Systems Hospitals of Little Rock, Arkansas, provide pathology services to their patients by contract with a group of eight pathologists, incorporated as Pathology Laboratories of Arkansas. A test of a blood or tissue specimen at one of the Hospitals leads to two charges: one from the Hospitals and one from Pathology Laboratories. The

Hospitals' bill (the "technical component") covers space, equipment, and technicians' services; Pathology Laboratories' bill (the "professional component") covers setting up test protocols, calibrating the equipment and supervising the testing, and, if necessary, interpreting the results and consulting with treating physicians. Pathologists are present or on call 24 hours a day. When they intervene to ensure that a test is done right, to recheck a surprising result, or to interpret ambiguous data, they do not submit a separate bill. The professional component, a fee of $2 to $5 per test, spreads costs across all patients —and in the process it avoids the need to keep records about just which test required just which services. Medical testing is a volume business, and bookkeeping to link particular services to particular tests could augment aggregate costs.

The Medicare program does not consider pathologists' oversight role to be a separate compensable unit of medical care. See 42 U.S.C. § 1395xx(a)(1), 42 C.F.R. § 405.550. For Medicare patients the Hospitals charge a fee including the pathologists' hands-off services, such as establishing test protocols. The Hospital pays Pathology Laboratories an annual lump sum for overseeing Medicare tests. Pathology Laboratories then submits a bill under Part B of Medicare for additional, hands-on services that it can document. Most private insurers, by contrast, are happy to pay separate bills at flat rates—to remit directly to Pathology Laboratories without requiring the Hospitals to serve as an intermediary, and to cover all of the pathologists' services in a single fee. This permits payment to vary with the number of tests conducted, but without the accounting problems of trying to attach specific fees to services on specific specimens. Both the Baptist Hospitals and Pathology Laboratories submitted bills to the Central States Health and Welfare Fund, which for years paid both. In November 1991 the Fund stopped paying the professional component bills, pointing to Article 4.11 of its Plan Document, which re-

stricts payment to the expenses of a person who "receives treatment". The professional component fee does not signify that the patient received any treatment by a pathologist and therefore, the Fund concluded, is not compensable. In 1992 the Fund—a multi-employer welfare fund governed by the Employee Retirement and Income Security Act—filed this suit under ERISA seeking restitution of payments made to Pathology Laboratories between 1986 and 1991. The Fund also sought an injunction that would bar Pathology Laboratories from billing the patients directly for the professional component.

Pathology Laboratories filed a counterclaim, seeking a declaration that the Plan Document permits payment of professional component fees. District Judge Duff granted summary judgment to the Fund on this counterclaim. 1994 U.S. Dist. LEXIS 9319 (N.D. Ill.). Pathology Laboratories accepts that decision. The case then was transferred to District Judge Bucklo, who held a bench trial on the Fund's claims. Judge Bucklo concluded in an oral opinion at the close of the evidence that the Fund had been aware of the nature of professional-component bills long before November 1991. Its own medical consultant told the Fund's staff in March 1989 what professional-component bills represented. Pathology Laboratories provided the same information in 1990. A judicial opinion also explained the practice as carried on by pathologists in Arkansas. *Arkansas Society of Pathologists v. Harris,* CCH Medicare & Medicaid Guide ¶ 30,546 (E.D. Ark. 1980). Instead of requiring the pathologist to prove that hands-on services were provided, and then paying one bill of (say) $125, private insurers willingly pay 20 bills of $5 each, with the difference reflecting administrative savings. Although the Fund thinks that separate bills increase total costs and that the Medicare approach would reduce outlays, because the Hospitals would drive a hard bargain with Pathology Laboratories, other payors do not share this conclusion. Because the Fund knew the industry practice and what these bills represented, and

because recoupment at this late date would be inequitable—the Fund's payment prevented Pathology Laboratories from billing the patients—the court denied the Fund's request for restitution. As for an injunction: the court observed that patients agreed when entering the Baptist Hospitals to pay all bills, whether or not the fees were covered by insurance, and it held that the coverage limitations in the Fund's Plan Document could not alter the patients' contractual commitments.

Let us start with this latter issue. The Fund submits that Judge Duff's decision means that Pathology Laboratories do not render medical services to the Hospitals' patients, and that ERISA prevents any state court from ordering patients to pay bogus bills for services not rendered. Yet Judge Duff did not find that Pathology Laboratories was submitting fraudulent bills. He concluded, rather, that the professional component does not represent "treatment" within the meaning of § 4.11 of the Plan Document because Pathology Laboratories cannot demonstrate that it provided hands-on services for any particular patient. That is a far cry from concluding that Pathology Laboratories is trying to pull a fast one. Pathology Laboratories provides supervisory services of value to all patients, and interpretation services of value to some. That its recordkeeping apparatus does not distinguish among them may be dispositive under § 4.11, but so what? Medical professionals provide many services for which insurance does not pay. A dental plan may pay for dentures but not crowns; a dentist who makes a crown still can bill the patient. A hospital plan may pay for a double room; a patient who requests a single room must expect to pay extra.

Nothing in ERISA prevents medical professionals from submitting—and state courts from enforcing—bills for services that are not covered by welfare benefit plans. Although ERISA preemtps state law that "relates to" plans, 29 U.S.C. § 1144(a), that clause does not annul

state laws of general applicability just because they affect the price of medical care. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995); *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 831-32 (1988); *Safeco Life Insurance Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995). The law of contracts does not fetter welfare benefit plans, or indeed any activity. Willingness to enforce private bargains facilitates rather than regulates commerce. Arkansas does not seek to compel the Fund to cover any particular medical service, or to reimburse providers any particular amount. Just as the Federal Aviation Act does not preempt enforcement of contracts that set the effective price of air transportation, see *American Airlines, Inc. v. Wolens*, 115 S. Ct. 817, 824-26 (1995), so ERISA does not preempt enforcement of contracts that specify who pays how much to whom for medical care. *Psychiatric Institute of Washington, D.C. v. Connecticut General Life Insurance Co.*, 780 F. Supp. 24, 32-33 (D. D.C. 1992). Enforcing a contract between patient and medical provider bypasses the welfare plan; it is hard to see how ignoring a plan could "relate to" a plan.

Insurers and welfare benefit plans may respond with contractual offers of their own. For example, they may make reimbursement contingent on providers' agreement to charge lower rates and to forego compensation from patients. This is normal in "preferred provider" organizations. Or they may adopt copayment plans under which patients *must* pay extra, and providers are not entitled to accept the plan's reimbursement as full payment. See *Kennedy v. Connecticut General Life Insurance Co.*, 924 F.2d 698 (7th Cir. 1991). ERISA does not prefer one of these contractual models over the other, and it does not oblige federal courts to take over the entire subject of medical care. By refusing to pay Pathology Laboratories' bills, the Fund disabled itself from extracting a quid pro quo such as an end to supple-

mental direct billing. The district court therefore properly declined to issue an injunction that would regulate contracts between Pathology Laboratories and its patients. This in turn supports the decision to deny restitution, because it shows that Pathology Laboratories could have collected from the patients had the Fund stopped paying before November 1991. Restitution would leave Pathology Laboratories without compensation for five years of services to the Funds' participants.

Restitution by pension and welfare funds is governed by federal common law in the shadow of ERISA. See *Central States Health & Welfare Fund v. Neurobehavioral Associates, P.A.*, 53 F.3d 172 (7th Cir. 1995); *UIU Severance Pay Trust Fund v. United Steelworkers of America*, 998 F.2d 509 (7th Cir. 1993); 29 U.S.C. § 1132(a)(3). Federal common law tracks the consensus of states, which have developed the law of restitution, see *UIU Severance Pay Trust Fund*, 998 F.2d at 513. We therefore turn to the *Restatement of Restitution* (1937), which summarizes the dominant themes of state common law. See also *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-15 (1989) (looking to the *Restatement of Trusts* as well as treatises on the state law of trust to flesh out the components of ERISA that bear the closest resemblance to trust law). And as § 1 of the *Restatement of Restitution* observes, restitution is a device to avoid unjust enrichment. A provider of medical care is not unjustly enriched by being paid the market fee for its services. The beneficiaries of the Fund's erroneous payments are the Fund's own participants, which avoided any need to compensate Pathology Laboratories for its services; yet the Fund has not sought restitution from them.

The Fund insists that it paid under a mistake of fact: it thought that Pathology Laboratories was supplying hands-on services (= "treatment"), and it wasn't. To bolster this contention, the Fund points to a brochure

from the College of American Pathologists, which the Fund depicts as offering a misleading description of professional-component billing. This sets up its appeal to the principle that sums paid under a mistake of fact are recoverable. E.g., *Hartford Accident & Indemnity Co. v. Chicago Housing Authority*, 12 F.3d 92, 97 (7th Cir. 1993); *Harnischfeger Corp. v. Harbor Insurance Co.*, 927 F.2d 974 (7th Cir. 1991). But the district judge found that the Fund knew the truth. Contrary testimony from the Fund's staff was deemed not credible. The district court's finding is not clearly erroneous. See *Anderson v. Bessemer City*, 470 U.S. 564 (1985). The Fund's staff was and is knowledgeable about compensation for medical care. It cannot have believed that bills of $2 to $5 per test represented the full charge for hands-on examination or interpretation. Nowhere in America have medical specialists' personal services been that cheap—not for a long, long time. Witnesses from Pathology Laboratories testified that they told the Fund's staff exactly how and for what services the firm billed. The Fund's own consultant conveyed the same information, yet the Fund continued to pay. Any mistake must have been one of law (that is, about the meaning of § 4.11) rather than of fact. But under § 45 of the *Restatement* the Fund's misinterpretation of its own governing documents does not permit it to recover payments made to someone with an "honest claim" to the money. Pathology Laboratories' claim to compensation is honest; the only question (from its perspective) was whether to bill the Fund or the patients. By paying until 1991, the Fund answered that question.

Almost in passing, the Fund points to Article 11.04 of its Plan Document, which provides that whenever it "has made payments exceeding the amount of benefis payable under the terms of this Plan, the Fund shall have the right to recover the excess payments from any responsible person or entity". Such a clause should be read broadly, the Fund insists, to facilitate prompt payment; for, if

it is hard to reverse errors, then welfare benefit funds will tarry before paying, providers will respond by raising their prices to recover the time value of money, and plan participants will be worse off. We grant the advantages of speedy payment, but it does not follow that a welfare benefit fund acquires the right to change the interpretation of its plan after providers of services have relied to their detriment. The district court found that the Fund knew all along what the bills represented and in November 1991 changed its view of how such bills should be handled. A change in interpretation makes it hard to call earlier payments "excess." The clearest example of an "excess payment" is one with an extra zero or two added to the check by mistake (in *Neurobehavioral Associates,* for example, the plan paid $1,000 to a provider that submitted a bill for $10); a good example of a payment "exceeding the amount of benefits payable under the terms of this Plan" would be payment of $500 for a service capped at $400 in a schedule, or payment for a single room when the plan provides for shared rooms. None of these things occurred here; instead we have a change in policy followed by an effort to make the new approach retroactive. Article § 11.04 does not call for retroactivity, which would violate another important policy: "preventing people from getting other people's property for nothing when they purport to be buying it." *Continental Wall Paper Co. v. Louis Vought & Sons,* 212 U.S. 227, 271 (1909) (Holmes, J., dissenting), quoted with approval in *Kaiser Steel Corp. v. Mullins,* 455 U.S. 72, 80 (1982). The real conflict is between the Fund and its participants; one or the other should pay Pathology Laboratories' bill, but the Fund wants to achieve a state in which neither has paid. Why should we leave physicians holding the bag? See, e.g., *City of Hope National Medical Center v. Superior Court,* 8 Cal. App. 4th 633, 10 Cal. Rptr. 2d 465 (Cal. App. 1992). Sometimes jurisdictional rules, or statutes of limitations, or conflicts between plans (each with a plausible argument

that the other is responsible), conspire to deprive medical providers of payment for real services, see *Foster McGaw Hospital v. Building Material Chauffeurs Welfare Fund*, 925 F.2d 1023 (7th Cir. 1991), but in this case the court had a choice. The district judge allowed Pathology Laboratories to keep its payment, and properly so.

AFFIRMED

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

No. 92 C 4141

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND, *et al.*,
Plaintiffs,

v.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.,
Defendant.

TRANSCRIPT OF PROCEEDINGS—TRIAL
BEFORE THE HONORABLE ELAINE E. BUCKLO

Chicago, Illinois

April 17, 1995

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* * * *

[195] MR. CONDON: Yes, and the second we have already cited in our summary judgment papers. We rely on our summary judgment papers.

I'm just taking a quick look.

The restatement sections—

THE COURT: I have read the restatement.

MR. CONDON: All right. Principally I'm relying upon those to indicate that an innocent as well as fraudulent misrepresentation is grounds for restitution.

And then with regard to the dictionary headings, I am simply buttressing my argument with regard to contractor interpretation, which is a question for the Court.

THE COURT: Right. Okay.

Well, to some extent this has been enlightening today. In other regards, I guess I don't feel like I have found out exactly what had happened, at least in the earlier years. As I just indicated, I really can't make anything out of expert testimony by deposition. I just can't evaluate credibility that way.

And I think that I have to make a distinction between what the patient should know and an insurance company ought to know. I agree that your average patient is probably in the dark, but I don't—or may well be, but it seems to me that an insurance company can be reasonably held to at least a little bit higher standard in terms of what it ought to know. In that [196] respect, I also think that it is true that Central States has the burden of proving that it is entitled to restitution.

Now, I gather that for a number of years, Central States was getting two bills, one from the hospital and another from this Pathology Laboratories. Apparently Central States never did anything about it. At least there is no evidence that it did. It does seem to me that Dr. Benafield's testimony makes sense, at any rate it isn't contradicted, that the kind of amounts being charged there are not the kind of amounts that you would expect ordinarily if a doctor I suppose was doing an analysis. At least that was his testimony. At any rate, it knew that it was getting two bills.

I get the sense from the testimony that this practice was generally widespread and, therefore, well-known. Now, it was certainly accepted in Arkansas. One of the things that had troubled me is, you know, Central States isn't in Arkansas, it's up here, and the fact that it's well known there, of course, doesn't necessarily mean that it is here. But apparently it also had been a Medicare practice and, you know, like this Judge Arnold opinion back

in 1980. I guess I can't sit here and say for sure that Central States did know about this. But it does seem to me that it has not shown that it really did not know.

I guess I also do not think that Mr. Murtha's testimony really takes me very far in terms of, you know, I had [197] asked Mr. Condon whether there was evidence that Central States didn't know, and I realize the difficulty in putting on some sort of testimony, but the fact that he trained people and he says, well, he would have looked at a bill, and he would have thought that this was for doctor's services, it seems to me to be too far removed to be able to rely on that as actual proof that they didn't know, considering the other evidence that it was widespread practice that there were two bills and that the amounts in the one bill should have made them suspicious.

So I think on the issue of whether there was a mistake, I don't think that Central States has proved its case. I think I have already indicated that with respect to the misrepresentation, which had troubled me because I agree that that brochure is not accurate. But the testimony today showed, as I said, I have already said, that Dr. Slaven told Mr. Murtha in April or March of 1990—is that where we are—that, exactly what the practice was, and I simply cannot credit his testimony that he was misled by the later brochure. I don't think he relied on it, and it makes no sense that he would not have called them or done something if he actually was going to rely on this brochure as opposed to the actual admission from someone on the phone that, yes, they weren't providing in many cases actual patient service in the sense in which Central States ultimately decided was required in order to make payment.

[198] It also seems to me that in terms of bad faith, I really can't find it otherwise in terms of its dealings with Central States, at least insofar as the evidence has shown here. They did put on evidence they weren't paid twice. It's not necessarily agree or disagree with the opinions that have said that this isn't the way things ought to be done. I don't—it just isn't—that issue is not before me.

Central States had, you know, as I indicated, they made their decision later on, and they chose to make it later on, but Central States certainly had its facts by 1990. Really I guess Central States probably at least was told by its own—it was told by its own medical consultant back in 1989 what the situation, was, at least with respect to some pathologists' bills, and Central States took some time for whatever reasons in making the decision to not pay that way, but I'm afraid Central States didn't reserve its right, it didn't say we are going to have to make a decision about this, and we may make the decision, and we are only going to pay you if you agree to pay us back.

And I think really, considering that it had all the knowledge that has been shown that it ever needed in terms of what was being done, which is different from what it wanted to do about that, that it's going to have to bear the burden of that, and I concluded that Central States has not shown that it's entitled to restitution. So I will deny the claim.

[199] Thank you. I'm sorry it's so late.

MR. BIERIG: Thank you very much, Your Honor. Thank you for spending to so much time with us today.

MR. CONDON: Thank you, Judge.

THE COURT: Thank you.

(Proceedings concluded.)

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

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92 C 4141

CENTRAL STATES, *et al.*

v.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.

MINUTE ORDER FORM

February 21, 1995

Plaintiffs' motion for summary judgment (81-1) on the issue of injunction is denied. Defendant's motion for summary judgment on that issue (86-1) is granted. Both parties' motions for summary judgment on the issue of reimbursement are denied. One day bench trial set for April 5, 1995 at 10:00 A.M. By March 29, 1995, parties to submit, lists of exhibits and witnesses along with any objections thereto, to chambers. Document number 85-1 is terminated as moot.

ORDER

On June 30, 1994, Judge Brian Duff entered summary judgment in favor of plaintiff Central States, Southeast and Southwest Areas Health and Welfare Fund and against defendant Pathology Laboratories of Arkansas, P.A., finding that Central States' determination that its Plan did not cover professional component charges for hands-off medical services was not arbitrary and capricious and therefore was lawful under ERISA, 29 U.S.C. § 1002 *et al.*, and that Central States had standing to seek an

injunction prohibiting Pathology Laboratories from seeking to collect the unpaid charges from Plan participants, as well as standing to seek reimbursement from Pathology Laboratories for reimbursement for charges previously and erroneously paid. Judge Duff left open the questions whether an injunction should actually issue and whether Central States' claim for reimbursement should be granted. After the parties briefed these issues, the case was transferred to my calendar.

I have concluded that an injunction should not be entered prohibiting Pathology Laboratories from any collection efforts. Central States concluded that a participant who does not receive a direct medical service from a pathologist does not "receive[] treatment" as required under the Plan. That does not, however, prohibit a participant from contracting with the physician for services. *See generally, e.g., Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund,* 900 F.2d 1138 (7th Cir. 1990); *Egert v. Connecticut General Life Insurance Co.,* 900 F.2d 1032 (7th Cir. 1990). In this case, the parties have stipulated that participants do sign a general assignment contract upon admission to the hospital which states that unless there is an express contract between the health provider and insurance company to the contrary, the participant agrees to be responsible for all "charges for services rendered." It is undisputed that there is no contract between Central States and Pathology Laboratories prohibiting Pathology Laboratories from seeking payment from the participant in this case. The parties also agree that Central States' conclusion that the service, if any, provided by Pathology Laboratories is not "treatment" as defined by the Plan would not be *res judicata* in any action by Pathology Laboratories against a participant in a state court seeking collection under the contract described above. Accordingly, I conclude that such an injunction would be improper. To the extent that Judge Duff concluded that ERISA preempts such a suit, I disagree.

Central States does, as previously found, have standing to seek a refund of payments improperly made. *Health Cost Controls v. Skinner,* 1995 U.S. App. LEXIS 111, *9 n.7 (7th Cir. Jan. 5, 1995). The parties have stipulated that if a refund is due, the amount owed is $30,000. They have also stipulated that Central States stopped payments in November, 1991, following their determination that the Plan does not cover the services provided. Beyond this, the facts are unclear. I have been unable to determine what period of time would be covered by the $30,000. At some point in time (in 1990), Central States knew (because their consulting physician told them) that the pathologists might be billing for indirect services. But sometime in 1990, Central States also received a brochure, sent by Pathology Laboratories, that could have been reassuring. Furthermore, sometime in 1990. Pathology Laboratories was clearly made aware that Central States was investigating the propriety of payments under the circumstances. The applicable rule appears to be stated in *City of Hope National Medical Center v. Superior Court,* 8 Cal. App. 4th 633, 636-37, 10 Cal.Rptr. 2d 465 (Cal. App. 1992): "[W]hen a payment is made based upon a mistake of fact, the payor is entitled to restitution unless the payee has, in reliance on the payment, materially changed its position. . . . Restitution will be denied, however, if the mistaken payment is made to a bona fide creditor of a third person—a creditor without fault because it made no misrepresentations to the payor and because it had no notice of the payor's mistake at the time the payment was made." In this case, contrary to Pathology Laboratories' view, I cannot say as a matter of law that the brochure sent to Central States did not contain a misrepresentation that may have been relied upon, resulting in a delay in stopping payment. It is also unclear whether Pathology Laboratories had enough information about the fact that Central States was disputing the claim that it can be said to have had no notice. (On the other hand, there is no evidence that Central States

paid the claims under a reservation of rights.) Thus, Pathology Laboratories may not be entitled to rely upon the innocent third party doctrine stated in *City of Hope* and the cases cited therein from other jurisdictions. But without more information I cannot make this determination. This claim cannot be decided on summary judgment.

ENTER ORDER:

/s/ Elaine E. Bucklo
ELAINE E. BUCKLO
United States District Judge

Dated: February 21, 1995.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

No. 92-C-4141

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND, *et al.*,
Plaintiff-counterdefendants,

vs.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.,
Defendant-counterplaintiff.

MEMORANDUM OPINION

I. *Undisputed Facts*

Plaitiff-counterdefendant Central States Southeast and Southwest Areas Health and Welfare Fund ("Central States") is a multi-employer benefit fund as defined in 29 U.S.C. § 1002(37)(A) (1993). Central States provides health care and other benefits to eligible participants, some of whom live in or around Little Rock, Arkansas. The benefits are provided pursuant to the terms and conditions of Central States, Southeast and Southwest Areas Health and Welfare Fund Active Plan Document (the "Plan").[1]

Defendant-counterplaintiff Pathology Laboratories is a group medical practice comprised of nine pathologists who practice at the Baptist Medical Systems Hospitals (the "Hospital"), in and around Little Rock, Arkansas. The

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[1] "Central States" refers to the benefit fund and its Trustees. Both are plaintiff-counterdefendants in this case.

pathologists work out of a laboratory located in the Hospital.

A non-Medicare patient who enters the Hospital and undergoes a clinical test will receive two separate bills for that test. The "technical component" charge is paid to the Hospital and covers, *inter alia*, the Hospital's cost for equipment and the salaries of the laboratory technicians who perform the lab tests.

A non-Medicare patient also receives a bill from the defendant for the "professional component" of the test. The professional component charge is assessed, even if a pathologist never performs a direct service for the individual patient. Pathology Laboratories bills the same amount per specific test, without regard to whether the test results were interpreted by a pathologist. The "professional component" is thus generally a charge for:

1. determining the appropriateness of test methodologies, sequences and instrumentation;
2. selecting ranges for normalcy for tests;
3. establishing guidelines for specimen identification and specimen quality;
4. reviewing quality assurance data;
5. defining the steps to be taken in reporting test results; and
6. reviewing the results of all clinical pathology procedures that require physician interpretation.[2]

If, for example, a Plan participant has a complete blood count test performed, a technician (employed by the Hospital) first draws the specimen, then loads it into an analyzer (owned and maintained by the Hospital),

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[2] For the sake of clarity and consistency with the terminology used in the parties' briefs, we will refer to these services as "hands-off" medical services. Reviewing, interpreting or analyzing test results will be referred to as "hands-on" medical services.

and next records the results. If the result is normal, no one from Pathology Laboratories ever sees the test result. Nonetheless, Pathology Laboratories establishes the procedures to be followed by the Hospials' technicians, sets the "normal" range for test results, establishes quality control procedures, and is available for consultation with the technician or treating physician.

Medicare patients are billed differently. Charges to Medicare are paid either from "Part A" or "Part B" of the Medicare plan. Part A provides insurance for hospital and hospital-related services. Part B provides insurance for supplemental medical services, including physician services. *See, College of American Pathologists v. Heckler,* 734 F.2d 859, 869 (D.C. Cir. 1984). In order to receive "Part B" payments (which tend to be higher), a hospital-based physician's services must satisfy the following criteria:

(1) the physician personally furnished services for an individual patient;

(2) the services contributed directly to the diagnosis or treatment of an individual patient;

(3) the services ordinarily require performance by a physician; and

(4) in the case of laboratory services, the additional requirements found in 42 C.F.R. §§ 405.552, 405.554 or 405.556 must be satisfied.

See 42 U.S.C. § 1395xx(a)(1) (1993); 42 C.F.R. § 405.550 (1993). These requirements were implemented in order to "check possible abuses in the Medicare system" and "to avoid paying for services at a level appropriate for physicians if those services are frequently and consistently (and more economically) furnished by non-physicians." *Heckler,* 734 F.2d at 864 (citations omitted.)

Since its clinical laboratory services do not satisfy these criteria, Pathology Laboratories entered into a reimburse-

ment contract with the Hospital. The Hospital is paid by Medicare for laboratory tests, and pays Pathology Laboratories an hourly rate for clinical services rendered, out of the Medicare payment. The contract specifically provides:

> *Compensation for Clinical Laboratory Services to Medicare Patients*: For compensation for clinical laboratory services and other administrative services furnished pursuant to this agreement to Medicare patients, System shall pay Corporation an hourly rate . . . for compensable hours of such services not to exceed payment of $235,322 per twelve (12) month accounting period. . . The total number of compensable hours shall be the total number of hours spent by the corporation in furnishing clinical laboratory services and other administrative services to Medicare patients as documented by time records, submitted pursuant to Provision 10a-1, of this agreement.

In November, 1991, after a lengthy investigation into the billing practices of Pathology Laboratories, Central States notified Pathology Laboratories that, unless it can show a specific service performed for a Plan participant, Central States would not pay for the professional component. Previously, Central States had paid for the professional component without regard to whether someone at Pathology Laboratories actually performed a direct service for a Plan participant.

Pathology Laboratories elected not to appeal Central States' decision to the Plan's Trustees. Instead, it billed Plan participants directly for professional component charges not paid by Central States. These bills were sent pursuant to an agreement signed by Plan participants upon their admission to the Hospital. (Exhibit B to Exhibit 3 of "Exhibits and Attachments to Pathology Laboratories' Memorandum in Support of its Motion for Summary Judgment.") When some of these participants

complained to Central States about the direct billing, Central States replied that it would pay only the technical component of the test charge since Pathology Laboratories had not performed any "actual services."

After Central States filed this law suit, Pathology Laboratories appealed Central States' decision to the Trustees. The issue presented to the Trustees at the November 11, 1992 appeal meeting was:

> Whether a pathologist has performed a direct service or treatment for the Fund's members and beneficiaries even when the pathologist does not perform a test on the patient or review a specified test result?

The following information was presented to the Trustees at the meeting:

1. A memorandum by Central States staff to the Trustees summarizing the staff's investigation of Pathology Laboratories' billing practices and recommending that the Board deny coverage for the hands-off aspect of the professional component;
2. An October 22, 1992 letter from John E. Slaven, M.D. (a member of Pathology Laboratories) setting forth the basis for the pathologists' position that Central States should cover all professional component charges;
3. A copy of the Pathology Services Agreement between Pathology Laboratories and Baptists Medical Systems;
4. Correspondence between Central States staff and Pathology Laboratories concerning the denial of certain professional component claims;
5. The complaint in this action;
6. Minutes of the Board of Trustees meeting of July 21, 1992 in which the Board was informed of this law suit;

7. Pathology Laboratories' answer to the complaint;

9. Memorandum dated March 21, 1989 from Dr. William B. Buckingham, M.D. recommending that the Plan not reimburse Pathology Laboratories unless a pathologist actually performs a service for a Plan participant.

The Trustees unanimously rejected the claims submitted by Pathology Laboratories for payment of charges for services which are not based upon the direct treatment or diagnosis by Pathology Laboratories to individual patients. The Trustees' decision was based on the following provisions of the Plan:

> ARTICLE IV, § 4.11
>
> Except as otherwise provided herein a claim for Basic Benefits or Major Medical Expense Benefits shall not be paid unless the Covered Individual is ill, injured, pregnant or an organ transplant donor, and receives treatment, compensable under this plan, related to the illness, injury, pregnancy or organ donation.
>
> ARTICLE XI, § 11.09
>
> In all instances, other than when a specific dollar amount in the state allowance, benefits to be paid by the Fund will be based upon a charge which is the usual, reasonable and customary charge for the treatment, supply of service, determined by comparison with the charges customarily made for similar treatments, supplies or services to individuals with similar medical conditions within a given geographical area.

After the Trustees rendered their decision, Central States filed an Amended Complaint seeking (1) a declaration that the charges for indirect services are unreasonable; (2) reimbursement for "professional component" charges previously and wrongfully paid; and (3) an injunction prohibiting Pathology Laboratories from undertaking collection efforts against the Fund's participants.

Pathology Laboratories filed a counterclaim seeking (1) a declaration that the professional component charges are covered by the plan; (2) a declaration that Pathology Laboratories may submit bills directly to Central States' participants; (3) compensation for injuries incurred as a result of Central States' "false and misleading statements;" and (4) injunctive relief. Both parties filed motions for summary judgment.

II. *Standard for Review*

Rule 56 of the Federal Rules of Civil Procedure requires this Court to enter summary judgment upon either party's motion "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." See generally *Celotex Corp. v. Catrett,* 477 U.S. 317 (1986). When there is enough evidence in favor of the non-movant that a fact-finder could reasonably return a verdict for that party, a "genuine issue" exists and summary judgment is not appropriate. *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 249 (1986). This court's task, therefore, is to determine which facts are material, in light of the relevant law, and then whether any of those facts are in dispute.

III. *Whether the Trustees' Decision was Reasonable*

Central States and Pathology Laboratories are asking for inverse declarations: Central States wants a declaration that the professional component charges are unreasonable and Pathology Laboratories wants a declaration that the professional component charges are in accord with the usual, customary and reasonable charges for pathology services and are therefore covered under the Plan. Thus, the primary question is whether there is a genuine issue of material fact as to whether, when a pathologist has neither interpreted nor reviewed the test

results of a Plan participant, there is coverage under the Plan.

A. *The Standard of Review.*

Central States' Trustees are delegated broad powers to construe the terms of the Plan; the Trustees' construction is binding. The decision to deny Pathology Laboratories' professional component charges is therefore subject to the arbitrary and capricious standard of review. *Egert v. Connecticut General Life Ins. Co.*, 900 F.2d 1032, 1035 (7th Cir. 1990). This standard requires us to give "great deference" to the Trustees' interpretation of the Plan. *Lister v. Stark*, 942 F.2d 1183, 1188 (7th Cir. 1991). Their decision will not be disturbed unless the record shows that the Trustees "entirely failed to consider an important aspect of the problem, offered an explanation for [their] decision that runs counter to the evidence before [them] or is so implausible that it could not be described to a difference in view or the product of [their] expertise." *Lister*, 942 F.2d at 1189 (citations omitted).

B. *The Basis for the Trustees' Decision.*

The parties have stipulated to the information considered by the Trustees in making their decision. We find, as a matter of law, that the Trustees considered all material aspects of the problem and that their decision is well supported by the evidence presented to them.

1. *There is No Genuine Dispute as to the Scope of the Trustees' Decision.*

In its memoranda, Pathology Laboratories has created a side issue which must be clarified before we consider the validity of the Trustees' decision. This issue concerns the conditions under which Central States will pay professional component charges.

Central States has repeatedly and unequivocally stipulated that it will pay only those claims for which Path-

ology Laboratories shows a pathologist interpreted or otherwise analyzed the test results of an individual Plan participant. (Stipulated Facts, Exh. 1, p. 3.) Instead of biting the bullet and admitting this fact, Pathology Laboratories draws a nonsensical distinction between "actual" services and "hand-on" services. It then claims that Central States denies payments for "actual" services that are "hands-off." This semantic gimmickry does not create a genuine question of fact as to the reasonableness of the Trustees' decision. Indeed, the question before us is not whether the "hands-off" services directly benefit the Plan's participants, but whether the Trustees' were unreasonable in determining that "hands-off" services were not covered under the Plan. *Cartelli v. Plumbers and Steamfitters Local Union No. 422 Pension Fund,* 1992 WL 6065 (N.D. Ill. 1992) (court will not review Trustees' decision *de novo*).

The Trustees were aware that Pathology Laboratories considered all clinical services to be "actual services" undertaken for the direct benefit of all patients who have been tested—Pathology Laboratories presented its position to the Trustees. Coverage under the Plan, however, is not contingent upon whether Plan participants directly benefitted from the pathologists' services. Moreover, the Trustees were not required to adhere to the determination by Pathology Laboratories that there is no material distinction between "hands-off" and "hands-on" services.

Finally, Pathology Laboratories cannot create a question of fact by misstating Central States' position on this issue. In its Local Rule 12m statement, Central States stated that it "will deny all claims submitted by clinical pathologists unless the pathologist has actually examined test results or prepared a report or analysis with respect to the test." (Plaintiffs' 12m statement at ¶ 20.) Pathology Laboratories "disputes" this statement by saying "Central States denied payment for clinical pathology services whenever its staff believes [sic] that the pathologist did not have 'hands on' involvement with the test.

This is true for all clinical pathology services—not only those relating to automated test." (Defendant's Response to Plaintiffs' 12m Statement at ¶ 20.) Central States' statement did not restrict its denial of coverage to "automated tests" only.[3] In any event, there is no genuine disagreement concerning the type of services for which Central States will provide payment ("hands-on") and that for which it will not ("hands-off").

2. *The Language of the Plan is Not Ambiguous.*

When the terms of an insurance policy are unambiguous, the interpretation of those terms is a matter of law to be decided by the Court. *Lulich v. Sherwin-Williams Co.*, 799 F. Supp. 64, 66 (N.D. Ill. 1992). "In general, 'contract interpretation is a subject particularly suited to disposition by summary judgment.' " *Id.*, (citations omitted). If the language of the contract is plain, the parties "can-

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[3] Pathology Laboratories' memoranda in this case contain many such straw-man arguments. For example, on page 7 of its Response/Reply, Pathology Laboratories implies that Central States denied the claims at issue because the claims were not for medical services. Pathology Laboratories then offers evidence that the professional component charges did include charges for medical services. A review of Central States, papers, however, reveals that it *never* claimed that the professional component did not reflect "medical services." It argued the services were not performed directly for a Plan participant. *See* Central States' Memorandum at p. 17, cited in Pathology Laboratories' Response/Reply at p. 7. Pathology Laboratories also alleges that Dr. Buckingham claimed there were only two other pathologist groups in the entire country which billed separately for the professional component. Reply/Response at p. 10. Pathology Laboratories then shows the falsity of this position and asks us to declare that the Trustees' decision based on this evidence was unreasonable. Dr. Buckingham *actually* testified that all but two laboratories which *provided services to Central States* billed "in the manner Medicare approves." Dr. Buckingham apparently further qualified his statement, but we were not given the benefit of his continued testimony. This style of argument skirts the line between advocacy and misleading the Court.

not create a genuine issue of material fact simply by urging different interpretations." *Harris Trust & Sav. Bank v. John Hancock Mutual Life*, 767 F. Supp. 1269, 1273 (S.D.N.Y. 1991), *aff'd* 970 F.2d 1138 (2nd Cir. 1991), *citing Hunt Ltd. v. Lifschultz Fast Freight, Inc.*, 889 F.2d 1274, 1277 (2nd Cir. 1989). Here, we find that the terms of the Plan are unambiguous, and that the Trustees' application of those terms to the professional component charges is in accord with the plain meaning of the terms of the Plan.[4]

a. Section 4.11 is Unambiguous.

Section 4.11 states:

> Except as otherwise provided herein, a claim for Basic Benefits or Major Medical Expense Benefits shall not be paid unless the Covered Individual is ill, injured, pregnant or an organ transplant donor, and receives treatment, compensable under this Plan, related to the illness, injury, pregnancy or organ donation.

There is nothing ambiguous about this provision. It states quite clearly that a claim will be paid only if the "Covered Individual . . . *receives treatment* . . ." Pathology Laboratories cannot create an ambiguity by interpreting the phrase "receives treatment" to include "setting parameters for tests results" and "reviewing quality assurance data." This is not "treatment" as the word "treatment" is understood in "an ordinary and popular sense." *Hammond v. Fidelity and Guar. Life Ins. Co.*, 965 F.2d 428, 430 (7th Cir. 1992) (citations omitted). We will not allow Pathology Laboratories to create an ambiguity where none exists.

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[4] Because we find that the terms of the contract are unambiguous, we do not reach the issue of whether the doctrine of *contra proferentum* (which we applied in *Phillips v. Lincoln National Life Ins. Co.*, 774 F. Supp. 495 (N.D. Ill. 1991), *aff'd* 978 F.2d 302 (7th Cir. 1992)) is appropriate in this case.

b. Section 11.09 is Unambiguous.

Section 11.09 of the Plan states:

> In all instances, other than when a specific dollar amount is the stated allowance, benefits to be paid by the Fund will be based upon a charge which is the usual, reasonable and customary charge for the treatment, supply or service, determined by comparison with the charges customarily made for similar treatments, supplies or services to individuals with similar medical conditions within a given geographical area.

It is undisputed that the Trustees did not perform an independent investigation into the billing practices of pathologists in Arkansas.[5] It is also undisputed that the Trustees were aware that many private carriers paid all professional component charges levied by Pathology Laboratories without requiring that a pathologist perform a direct service for a covered individual. Dr. Slaven's letter to the Trustees explaining the prevalence of this billing procedure is very clear. In light of Dr. Slaven's report, we cannot agree with Pathology Laboratories that the Trustees did not consider whether the professional component was a "usual and customary" charge in Arkansas, as required by § 11.09.

It is, however, also undisputed that certain carriers do *not* pay for the professional component of a test. It is further undisputed that Medicare will not pay pathologists directly for the professional component charges. Not paying for the professional component when no direct service

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[5] We are not certain that the Plan requires an investigation. Pathology Laboratories cites to the definition of "reasonable and customary" found at § 1.55. This section states the "reasonable and customary" means "a statistical compilation of the customary charges *incurred by Participants* and Dependents of Central States Health and Welfare Fund, as described in § 11.09." (emphasis added). In other words, it appears to mean that the Plan will only pay for charges if the amount of the charge is in accord with what the Plan usually pays for such a charge.

has been performed is therefore neither "uncommon" not "uncustomary." Indeed, the charges made to these "minority" carriers and Medicare are charges "customarily made for similar treatments, supplies or services to individuals with similar medical conditions within a given geographical area." The Trustees' determination that the "minority" method of payment was also more reasonable under § 11.09, will not be disturbed.

There is nothing in § 11.09 or in any of the other evidence provided which requires Central States to pay a claim simply because most other private carriers would pay the claim if it were presented to them. If Central States were required to adhere to the most prevalent billing practice, it (and other insurance providers operating under similar language in their plans) could *never* root out unfair or inaccurate billing practices, as long as the less diligent and less cost conscious of its brethren continued to write such checks to health care providers. Certainly the law does not support this conclusion.

Thus, Pathology Laboratories has failed to raise a genuine issue of material fact as to whether Central States' decision not to pay the professional component was an arbitrary and capricious construction of § 11.09.

3. *The Trustees Considered All Relevant Evidence.*

Pathology Laboratories argues that the Trustees should have based their determination on § 1.24 of the Plan and on certain guidelines to the Plan's implementation. These provisions were not considered by the Trustees and, Pathology Laboratories argues, provide coverage for the professional component. We find that the Trustees' failure to consider these provisions does not constitute the failure to consdier "an important aspect of the problem." *Lister*, 942 F.2d at 1189. In fact, the language in these provisions support the Trustees' decision.

a. Section 1.24(a).

Section 1.24(a) of the Plan defines covered "eligible major medical expenses" as:

> reasonable and customary charges incurred by a Covered Individual for medical services, supplies and treatments performed or prescribed by a physician, including . . . charges by a physician or surgeon for professional services.

Central States does not contest that pathologists are physicians who perform professional services. It is also undisputed that Central States will pay for professional services when those services are *incurred* by a Plan participant. A Plan participant does not "incur" the professional component charge simply because Pathology Laboratories elected to bill patients for services it provides to the laboratories run by the Hospital. What did the patient do to "incur" the professional component charge, other than submit to a test taken, analyzed and reported by the Hospital?

The decision of the Trustees requires the defendant to show that the charges it levied against a Plan participant were actually "incurred" by that participant. There is nothing in § 1.24(a) which compels or even implies a determination that the Plan must pay a fee to cover the pathologists' costs for providing indirect medical services. Pathology Laboratories' interpretation of § 1.24 is supported neither by the plain meaning of § 1.24 nor by the word "incurred" as it is commonly understood. *Hammond,* 965 F.2d at 430. We find, as a matter of law, that the Trustees' decision does not run contrary to the plain meaning of § 1.24.

b. The Guidelines.

Its 1985 internal guidelines advise the staff of Central States to approve payments for the "professional component" charge submitted by a radiologist or a patholo-

gist. Pathology Laboratories asserts that the decision of the Trustees was contrary to the Plan's own guidelines, and was therefore unreasonable.

A review, however, of the entire text of the guideline shows that "professional component" is defined as a charge "made by a radiologist or pathologist for his/her professional charge for *taking and interpreting* the x-ray or laboratory procedure." (Pathology Laboratories Exhibits and Attachments, Exhibit 1, attachment C) (emphasis added). Central States will pay for professional component charges if the pathologist can show that he or she actually "took or interpreted" a lab test. Thus, the Trustees' decision is not contrary to the Plan's guidelines, and is neither arbitrary nor capricious.

4. *The Case Law Cited by Defendant is Not Persuasive.*

The Trustees' determination of whether the Plan provides coverage for the professional component charges is not controlled by the authority cited by Pathology Laboratories. None of these cases considered the matter at issue here, *i.e.* whether the Plan provides coverage for the "hands-off" services performed by pathologists. *See e.g., Indiana State Dept. of Public Welfare v. Nucleopath Inc.*, 536 N.E.2d 1045 (Ind. App. 1989); *American Medical International, Inc. v. Scheller*, 590 So. 2d 947 (Fla. App. 1991).

The decision in *Arkansas Society of Pathologists v. Harris*, [1980 Transfer Binder] Medicare and Medicaid Guide (CNN) ¶ 30,546 (E.D. Ark. 1980) has only limited persuasive authority. First, the court itself characterized its decision as "provisional" and "subject to change." 10,117. Further, the *Harris* court's determination that the practice of clinical pathology was a "professional service" was a determination of fact, not of law. 10,118. Finally, the *Harris* court was interpreting a Medicare statute which has been revoked. Thus, the *Harris* case

does not substantially support the position that the Trustees' decision was arbitrary and capricious.

C. *Summary Judgment Is Appropriate on This Issue.*

For the reasons discussed above, we grant Central States' motion for summary judgment on its claim for (1) a declaration that Pathology Laboratories' professional component charges are unreasonable and not covered by the Plan, unless a pathologist has interpreted a test result for Plan participant; and (2) a declaration that Pathology Laboratories is not entitled to recover the professional component charges unless it can show it analized or otherwise reviewed a test result from a Plan participant.

IV. *Central States' Claim for Injunctive Relief*

In its Amended Complaint, Central States requested an order enjoining Pathology Laboratories from billing directly Plan participants for the professional component charges not paid by Central States. Although it is not clear from its papers, Pathology Laboratories appears to ask us to find that Central States does not have the standing to bring this cause of action.

Pathology Laboratories' patients who are also Plan participants have signed an agreement to pay Pathology Laboratories for any charges not covered by the Plan. The defendant argues that this agreement creates a contractual relationship under Arkansas state law which is not preempted by ERISA and that Central States has no standing to seek the injunction. We disagree and rule that Central States has standing to bring a suit to enjoin Pathology Laboratories from billing Plan participants directly for the professional component.

First, the agreements at issue are preempted by ERISA. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit

plan. . ." 29 U.S.C. § 1144(a). We follow the Supreme Court's instruction that the term "relate to" be given "its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 47 (1987) (citations omitted). Clearly the patient agreements relate to the Plan because the agreement is only relevant if the Plan denies coverage. Pathology Laboratories would not seek payment from the Plan participant unless the Plan does not provide coverage.

Second, adopting Pathology Laboratories' position would allow it to supplant the Trustees' determination that the professional component did not reflect the performance of an actual service for the Plan participant. This is contrary to the legislative purpose underlying ERISA. *Pilot Life,* 481 U.S. at 46. If Central States is not competent to enjoin Pathology Laboratories from direct billing, Pathology Laboratories would be able, through state contract law, to accomplish that which is prohibited under ERISA. Under these circumstances, federal courts have found that the state law claims are preempted. *See e.g., Oaks Psychiatric Hosp., Inc. v. American Heritage Life Ins. Co.,* 814 F. Supp. 553, 556 (W.D. Tex. 1993), *citing Herman Hosp. v. MEBA Medical & Benefits Plan,* 845 F.2d 1286, 1290 (5th Cir. 1988).

Finally, Central States is protecting the *interests* of its participants by seeking to enjoin Pathology Laboratories from enforcing the agreement. Protecting the interests of participants is an action which falls under ERISA's broad unbrella. Congress intended ERISA to provide a comprehensive and exclusive civil enforcement scheme that would protect the interests and benefits of ERISA-plan participants. *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 113 (1989).

The defendant relied heavily on *Psychiatric Institute of Washington, D.C. v. Connecticut General Life Ins. Co.,*

780 F. Supp. 24, 28 (D.D.C. 1992). That case is easily distinguishable. In *Psychiatric Institute,* the contract between the patient and the care provider became an issue only because the carrier claimed the *patient* was not covered under its policy. In that case, and in the hypothetical offered by Pathology Laboratories in its Memorandum, the interests of the plan and its participant were diverse. Here, the Trustees, acting in their capacity as ERISA fiduciaries, made an informed decision that Pathology Laboratories' fees were not fees for treatment performed on a Plan participant. They were acting to protect the health care interests of the Plan's participants, and should be allowed to carry their protective action through to its conclusion.

We therefore find that Central States has standing to bring a suit to enjoin Pathology Laboratories from billing Plan participants directly for the professional component charges not covered by Central States.

V. *Central States' Claim for a Refund for Past Payments*

Pathology Laboratories also asks us to find that Central States' refund action is barred under the Seventh Circuit's *dicta in Connors v. AMAX Coal Co., Inc.,* 858 F.2d 1226 (7th Cir. 1988). In that case, the Seventh Circuit noted that "[s]ection 502(a)(3) [of ERISA] does not apply to suits by fiduciaries to recover money that they paid to outside entities in violation of ERISA or the plan." 858 F.2d at 1229, f.n. 4. Here, Pathology Laboratories is not an "outside entity," but an assignee of its "patients" who are also Plan participants. (Counterclaim at ¶¶ 43-44.) Pathology Laboratories should not be allowed to bring suit pursuant to ERISA and then claim to be immune from a related ERISA suit because it is an "outside entity."

Also, the *Connor* court was discussing whether § 502(a)(3) conferred jurisdiction, not whether a cause of action for refund exists. Consequently, that authority

does not compel dismissal of Central States' claim for a refund.

VI. *Pathology Laboratories' Claim for Defamation*

Pathology Laboratories has asked us to grant summary judgment on its common law claim for defamation *per se*. Rather than cite binding legal authority in support of its motion, Pathology Laboratories moves for a judgment *as a matter of law*, on the legal authority of a comment in a law review.

Parties represented by counsel should not burden courts with the task of performing the legal research and analysis necessary to support the party's dispositive motion. There is considerable Arkansas case law discussing the tort of defamation and we find inexcusable Pathology Laboratories' failure to rely on case law. *See e.g., Waymire v. DeHaven*, 858 S.W.2d 69 (Ark. 1993); *Wal-Mart Stores, Inc. v. Dolph*, 825 S.W.2d 810 (Ark. 1992); *Ransopher v. Chapman*, 791 S.W.2d 686 (Ark. 1990); *Little Rock Newspapers, Inc. v. Dodrill*, 660 S.W.2d 933 (Ark. 1983). We assume the defendant cannot find any case law to support its positions.

We deny Pathology Laboratories' motion for summary judgment on its counterclaim for defamation *per se*, because the facts in this case do not support its claim. We cannot dismiss the defamation claim at this time because Central States has not moved for summary judgment on Pathology Laboratories' counterclaim but merely asked us to dismiss the claim in its Reply Brief. *English v. Cowell*, 10 F.3d 434, 437 (7th Cir. 1993).

VII. *Conclusion*

We find that there is no genuine issue of material fact in dispute concerning the reasonableness of the Trustees' decision to condition payment for the professional component charges on a showing by Pathology Laboratories that the charge represents a "hands-on" service performed

by Pathology Laboratories. The Trustees considered all important aspects of the problem, and their application of the Plan to the issue presented was neither arbitrary nor capricious. We declare that the Trustees' decision was reasonable, as a matter of law, and that the charge for the professional component is therefore unreasonable. We also declare, as matter of law, that Pathology Laboratories is not entitled to recover the professional component charges, unless it can show that it reviewed or interpreted the test result of a Plan participant.

We further find that Central States has standing to bring its claim for injunctive relief and standing to seek reimbursement for past payments. Finally, we deny Pathology Laboratories' Motion, in its entirety.

ENTER:

/s/ Brian Barnett Duff
BRIAN BARNETT DUFF
Judge
United States District Court

DATE: June 30, 1994

[Logo]

CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE FUND

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND ACTIVE PLAN DOCUMENT

8550 W. Bryn Mawr Ave.
Chicago, IL 60631-3275
1-800-323-5000

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND ACTIVE PLAN DOCUMENT

8550 W. Bryn Mawr Ave.
Chicago, IL 60631
312-693-5300
Toll Free 1-800-323-5000

* * * *

This Plan Document Copy Printed September 1987

ARTICLE IV. GENERAL CONDITIONS FOR PAYMENT OF CLAIMS

4.01 PAYMENT ONLY FOR COVERED CLAIMS OF COVERED INDIVIDUALS

The Plan shall not pay any claim for benefits unless the benefits are provided by the Plan, the claimant is a Covered individual and the claim for benefits is submitted in proper form as determined by the Fund.

4.02 LIMITATION ON PAYMENT FOR TREATMENT NOT CONSIDERED STANDARD MEDICAL CARE

The Plan shall not pay any charges for care, treatment, services and supplies which are not uniformly and professionally endorsed by the general medical community as standard medical care, treatment, services and supplies.

4.03 LIMITATION ON PAYMENT FOR TREATMENT IN A GOVERNMENT OPERATED FACILITY

The Plan shall not pay any charge incurred for treatment or service furnished by any facility contracted for, or operated by, the United States government or any other governmental unit, unless the Covered Individual is legally required to pay any or all of said charge. The Plan shall specifically not pay any charge incurred for treatment or services provided by the Veteran's Administration or Public Health Service Hospitals, unless the Covered Individual would be liable for these charges regardless of Coverage under this Plan.

4.04 LIMITATION ON PAYMENT OF CLAIMS ARISING FROM WORK-RELATED INJURY OR COVERED BY WORKER'S COMPENSATION

The Plan shall not pay any charge incurred for any treatment or service for illness or injury which is sus-

tained as a result of any enterprise or occupation for wage or profit or is covered by an applicable Worker's Compensation Act or similar law.

In the event that a Covered Individual is awaiting disposition of a Worker's Compensation claim by a Worker's Compensation Commission because coverage for the illness or injury is disputed, that Individual may be eligible to receive some benefits. (See Section 11.15)

After a five (5) year period from the date of Disability, any complication arising from the illness or injury shall be deemed payable in accordance with the Plan provisions, unless it is still compensable under Worker's Compensation.

4.05 LIMITATION ON PAYMENT FOR TREATMENT OF INJURIES SUSTAINED WHILE IN ANY ARMED SERVICE

The Plan shall not pay any charge incurred for treatment or service due to illness or injury sustained while in any Armed Service or for treatment of any complication of such illness or injury. After a five (5) year period from the date of Disability, any complication arising from the illness or injury shall be deemed payable in accordance with the Plan provisions.

4.06 LIMITATION ON PAYMENT FOR TREATMENT DUE TO ILLNESS OR INJURY ARISING OUT OF ANY ACT OF WAR OR CIVIL DISTURBANCE

The Plan shall not pay any charge incurred for treatment or service due to illness or injury arising out of declared or undeclared war or any act of war or civil disturbance, including riots, demonstrations and marches or for treatment of any complication of such illness or injury. After a five (5) year period from the date of Disability, any complication arising from the illness or injury shall be deemed payable in accordance with the

Plan provisions, unless it is compensable by an Other Plan or government agency.

4.07 LIMITATION ON PAYMENT FOR TREATMENT OF INJURIES ARISING AS A RESULT OF PARTICIPATION IN CRIMINAL CONDUCT

The Plan shall not pay any charge incurred for treatment or services due to injury, and any complication thereof, sustained as a result of willful or knowing participation in conduct which is in violation of any State or Federal Criminal Statute. The Fund shall have the right to recover the amount of any payment upon discovery that the injury for which payment was made resulted from willful or knowing participation in conduct which is in violation of any State or Federal Criminal Statute.

4.08 LIMITATION ON PAYMENT FOR TREATMENT RECEIVED OUTSIDE THE UNITED STATES, ITS PROTECTORATES, CANADA OR MEXICO

The Plan shall not pay any charge incurred for treatment or services received outside the United States, any of its protectorates, Canada or Mexico.

4.09 LIMITATION ON PAYMENT FOR TREATMENT CONNECTED WITH SURGERY FOR COSMETIC PURPOSES

The Plan shall not pay any charge incurred for treatment or service connected with surgery performed for cosmetic purposes, even if performed for psychological reasons, unless the treatment or service is medically required as a result of accidental bodily injury.

This limitation includes, but is not limited to:

(a) Surgery for obesity, including gastric bypass, gastric stapling, intestinal bypass, lipectomy,

suction lipectomy, and any other surgical procedure, the purpose and result of which is primarily to remove adipose tissue.

(b) Reduction mammoplasity.

(c) Augumentation mammoplasty, unless unilateral/bilateral and part of reconstructive surgery for the treatment of malignancy of the breast necessitating removal of a portion or all of the breast tissue.

(d) Rhinoplasty, unless the patient has sustained a traumatic fracture of the nasal seqtum, or unless the patient has nasal obstruction and the procedure is undertaken to relieve this obstruction.

(e) Otoplasity for irregular deformity or macrotia. This is sometimes referred to as plastic surgery for lop ears or cauliflower ears.

(f) Blepharoplasty, or repair of drooping eyelids. unless the droop of the eyelids is such as to restrict the field of vision and the visual field restriction is documented by the opthalmological consultant.

(g) Radical Keratectomy or Keratotomy, unless the patient has myopia of such a severe degree that it cannot be corrected by lenses.

(h) Rhytidectomy (face lift).

(i) Dysnronia (tatoo removal).

(j) Panniculectomy or lipectomy.

(k) Genioplasty (chin augmentation).

4.10 LIMITATION ON PAYMENT FOR TREATMENT OTHERWISE COVERED UNDER THE SOCIAL SECURITY ACT

The Plan shall not pay any charge incurred for treatment or service to the extent that such charge is covered or provided by the Social Security Act, as amended, except as provided in Article V.

4.11 LIMITATION ON PAYMENT FOR TREATMENT NOT RELATED TO ILLNESS, INJURY OR PREGNANCY

Except as otherwise provided herein, a claim for Basic Benefits or Major Medical Expense Benefits shall not be paid unless the Covered Individual is ill, injured, pregnant or an organ transplant donor, and receives treatment, compensable under this Plan, related to the illness, injury, pregnancy or organ donation.

4.12 LIMITATION ON PAYMENT FOR CERTAIN DENTAL TREATMENTS

Except as provided below, the Plan shall pay Basic Benefits, as outlined in Article XII, and Major Medical Expense Benefits, as outlined in Article XIII, for charges incurred in connection with dental operations, only if prescribed by a Physician as a result of a medical condition and as approved by the Fund, or for hospital confinements where the patient or condition is any one of the following:

(a) Dependent child three years or younger;

(b) Physically handicapped child or adult;

(c) Mentally handicapped child or adult (includes those with Cerebral Palsy);

(d) Bell's Palsy;

(e) Hemophilia;

(f) Asthma. Chronic Obstructive Lung Disease, or Chronic Obstructive Pulmonary Disease;

(g) Heart Disease, Diabetes or Hypertension, provided that eligibility for benefits is approved by Fund Medical Consultants prior to hospital confinement.

The Plan shall not pay Basic Benefits or Major Medical Expense Benefits for dental materials or dental procedures, except as outlined in Section 15.06.

4.13 LIMITATION ON PAYMENT FOR TREATMENT OF NON-COMPENSABLE PROCEDURES

The Plan shall not pay any charge incurred for treatment of complications arising from the performance of any procedure not compensable under this Plan.

4.14 LIMITATION ON PAYMENT FOR ROUTINE PHYSICAL EXAMINATIONS

The Plan shall not pay for any charge incurred in connection with routine physical examinations, including diagnostic procedures.

4.15 LIMITATION ON PAYMENT FOR CERTAIN ITEMS

The Plan shall not pay any charge incurred for sales taxes, surcharges, interest, late charges, completion of any claim form or missed appointments.

4.16 LIMITATION ON PAYMENT FOR CUSTODIAL CARE

The Plan shall not pay any charge incurred for Custodial Care, as defined in Section 1.18.

4.17 LIMITATION ON PAYMENT OVER PRESCRIBED MAXIMUMS

The Plan shall not pay any charge which would exceed the stated maximum, scheduled fee or stated percentage of covered charges payable as set forth in Article XX of the Plan unless "balance under Major Medical" immediately follows such reference.

4.18 LIMITATION ON ELIGIBILITY FOR COVERAGE OF CERTAIN ORGAN OR TISSUE TRANSPLANTS

Benefits for bone marrow, heart, heart/lung, liver, lung and pancreas transplants, including all related services, are payable only if the recipient provides requested documentation for consideration by the Fund's Medical Consultants on a pre-admission basis. Such documentation will include, but may not be limited to, written opinions by Physicians associated with the case testifying to the following:

(a) Absence of significant co-existing morbidity.

(b) Evidence of medical suitability of candidate for transplanation.

(c) Criteria for patient selection is in agreement with published medical literature.

(d) Alternative procedures, services or courses of treatment are not effective or available.

(e) Facility and physicians involved in transplant services have appropriate approval by regulatory agencies and from internal authorities.

After consideration by the Fund's Medical Consultants, each case will be brought to the Trustees for their review. No organ or tissue transplant proposed for coverage under this Section will by payable unless there is prior approval by the Trustees following their consideration of the circumstances of each case.

* * * *

ARTICLE XI. MISCELLANEOUS PROVISIONS

11.01 VALIDITY OF CHANGES IN THE PLAN

No agent has authority to change the terms of this Plan or to waive any of its provisions. No change in this Plan shall be valid unless adopted by the Trustees of the Fund.

11.02 CLAIM FORMS

The Fund, upon written request of the claimant, will furnish to the claimant such forms as are required for filing a claim.

11.03 TIME WITHIN WHICH CERTAIN CLAIMS ARE TO BE FILED

A Claim for any loss (excluding Prescription Benefits, Total and Permanent Disability or Waiver of Premium) must be filed within one (1) year after the date of such loss. A claim for Prescription Benefits must be filed within two (2) years after the date such prescription drugs were dispensed. A claim for Total and Permanent Disability or Waiver of Premium must be filed within three (3) years after termination of Coverage.

11.04 RECOVERY OF EXCESS PAYMENTS

Whenever this Plan has made benefit payments exceeding the amount of benefits payable under the terms of this Plan, the Fund shall have the right to recover the excess payments from any responsible person or entity, including the right to deduct the amount of excess payments from any subsequent payable benefits.

11.05 FUND MAY ORDER PHYSICAL EXAMINATION AND/OR AUTOPSY

The Fund shall have the right and opportunity to have a claimant examined by a medical service provider, of the

Fund's choosing and at the Fund's expense, when, and so often as it may reasonably require during the pendency of a claim. In the case of death, the Fund shall also have the right to request an autopsy where it is not forbidden by law.

11.06 TO WHOM BENEFITS ARE PAYABLE

All benefits are payable to, or for the benefit of, a Covered Individual or his estate, except as otherwise provided in this Plan.

11.07 CERTAIN ACTS OF THE FUND DO NOT CONSTITUTE A WAIVER OF RIGHTS

The furnishing of forms by the Fund for filing a claim for benefits, or the acceptance of such filings or the investigation of any claim hereunder, shall not operate as a waiver of any rights of the Fund.

11.08 NO MEDICAL EXAMINATION REQUIRED AS PREREQUISITE TO COVERAGE

In no case shall any individual be required to submit to a medical examination as a prerequisite to Coverage under this Plan.

11.09 ALL BENEFIT PAYMENTS BASED ON REASONABLE AND CUSTOMARY CHARGES FOR THE SERVICES

In all instances, other than when a specific dollar amount is the stated allowance, benefits to be paid by the Fund will be based upon a charge which is the usual, reasonable and customary charge for the treatment, supply or service, determined by comparison with the charges customarily made for similar treatments, supplies or services to individuals with similar medical conditions within a given geographical area.

* * * *

49a

HEALTH

and

WELFARE

ADMINISTRATIVE

PROCEDURES

MANUAL

MEMORANDUM

DATE: March 8, 1995

TO: Thomas Hoops
Dave Secrest
Anita Cordero
Craig Forrester
Patricia Dwyer
Charyl Kavner
Robert Rybicki

FROM: Eileen Ferguson

RE: Revised Policies

Attached please find a Policies and Procedure manual of Health and Welfare Administrative procedures which have been approved by Ron Kubalanza.

We will update these periodically as procedures change or are added.

If you have any questions, please let me know.

/s/ Eileen
EILEEN FERGUSON

EF:jkb

Attachment

cc: Ronald J. Kubalanza

CENTRAL STATES
HEALTH AND WELFARE FUND
POLICIES AND PROCEDURES

SUBJECT	EFFECTIVE DATE	REVISION DATE	PAGE OF
LABORATORY AND/OR X-RAY INTERPRETATION— INPATIENT	1/15/85		

If a hospital bill contains a professional charge for X-Ray or Laboratory interpretation, this should be considered as a radiologist or pathologist charge (Professional Component *) and paid under the Hospital Miscellaneous Expense benefit/service code.

If the Radiologist or Pathologist submits a separate bill for the Professional Component charge, this charge is still payable under the Hospital Miscellaneous benefit using the appropriate benefit/service code.

---

* *Professional Component Charge:* A charge made by a radiologist or pathologist for his/her professional charge for taking and interpreting the X-ray or Laboratory procedure.

Approve _____ Deny _____

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

No. 92 C 4141

CENTRAL STATES SOUTHEAST and SOUTHWEST AREAS HEALTH AND WELFARE FUND, *et al.*,
Plaintiffs,

v.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.,
Defendant.

TRANSCRIPT OF PROCEEDINGS—TRIAL
BEFORE THE HONORABLE ELAINE E. BUCKLO

Chicago, Illinois
April 17, 1995

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* * * *

[43] Q. Where you see $2.70?
A. Yes, sir.
Q. Now, Mr. Murtha, did your claims adjusters believe that the pathologist had specifically reviewed this specimen, reviewed this slide and written up a report for the attending physician on that, on that test?
A. I believe so, and that's how I trained adjusters prior to my understanding of what was really going on in this billing practice.

Q. You had trained the adjusters?

A. I had trained adjusters.

Q. And you trained them to do what exacly?

A. Well, how to process these bills, and there is this, you know, how to process these bills and wha they reflect.

Q. And did you discuss with them the ssue of professional component billing for clinical patholgy?

A. I'm not sure what issue. You know, when I was training adjusters, I told them what I knew hat to be at the time I was training, and my understanding at that time was that a physician had looked at this test, nade an evaluation, and became, provided an interpretatio.

Q. So you discussed hematocrit testing?

A. Well, I would never get to that level of detail. No. When you see a bill from a pathology or a laboratory test, that this bill represents the physician's interpretation and

* * * *

[Logo]

CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE FUND

CERTIFIED MAIL/RETURN RECEIPT REQUESTED

April 25, 1990

Pathology Lab of Ark. P.A.+
Med Towers Building 1120
9601 Lile Drive
Little Rock, AR 72205-6350

RE: LEVEL III CLAIM APPEAL
MEMBER: WILLIAM HALL (DECEASED)
S.S. #432-24-1326
YOUR ACCOUNT NO.: 37335-40
OUR CLAIM NO.: 918171960
HOSPITAL'S PATIENT CONTROL NO.:
5519-89

Dear Pathology Lab of Ark. P.A.+:

Our member's wife, Mrs. Hall is appealing our denial of your bill for services incurred during Mr. Hall's hospitalization of March 4, 1989 through April 19, 1989 in the amount of $2,469.60. A review of the $68,082.21 hospital bill shows that Baptist Medical Center also charged a fee for the laboratory charges in the amount of $6,788.70.

Before we can present this issue to the Board of Trustees at their next regularly scheduled meeting, we need an explanation as to why we have been billed from both providers? What services were performed by each to justify separate charges? I am sending Baptist Medical Center a copy of this letter.

Please send any statements, documents or explanations that you have within 30 days to my attention at the address below. Thank you for your cooperation.

Sincerely,

/s/ Cheryl Storc
CHERYL L. STORC
Level III
Health and Welfare Analyst
Research and Correspondence Department

CLS:dlr0418-118

cc: Local Union No. 878
Michael J. D'Onofrio, Group Manager, Health and Welfare
Mrs. Laura Hall
Baptist Medical Center

[Logo]

PATHOLOGY
LABORATORIES
OF ARKANSAS, P.A.

Medical Towers Building
Suite 1120
9601 Lile Drive
Little Rock, Arkansas 72205
(501)225-7711

June 25, 1990

Central States
Southeast and Southwest Areas
Health and Welfare Fund
9377 W Higgins Rd.
Rosemont, Il 60018-4938

RE: Level III Claim Appeal
Pt: William Hall
Acc 37335-40

Dear Ms. Cheryl Storc:

Enclosed is a pamphlet. The Laboratory Connection, an explanation of the role of Pathology in Medical Care. This pamphlet will help explain what services were performed by each to justify separate charges. If you have any further questions please feel free to contact our office.

/s/ Becky Martin
BECKY MARTIN
Collection Manager

57a

THE

LABORATORY

CONNECTION

An explanation
of the role of
PATHOLOGY
in medical care.

WHAT HAPPENS NEXT?

The findings are reported to your physician. Armed with this valuable information, and aided by the pathologist in evaluating the test results, your physician now has the scientific basis for selecting the best possible treatment for you. A proper decision can now also be made on whether hospitalization is appropriate or whether your condition can be treated effectively while you go on about your normal daily life. Your doctor may order continued laboratory tests during treatment to be sure medication is at the correct dosage and working as desired, that it is compatible with other medications you may be taking, to determine that your system is responding to the treatment, and to reveal any possible side effects.

ARE LABORATORY TESTS EXPENSIVE?

The fees for your laboratory procedures are of course based upon the number and kinds of tests performed. Rates vary for different tests, since some must be performed individually and unhurriedly, with personal concentration on detail, while others can be done rapidly, and accurately by maximum or computers. For certain xxxx xxxxxx procedures, the pathologist personally attends the patient and supervises the processes.

What you pay for is the security of being able to rely upon the accuracy of the test results—and what they tell about your condition—due to the rigid system of quality control maintained by the pathologist directing the laboratory.

HOW WILL I BE BILLED?

If you receive two statements for your laboratory work, one will be from the pathologist and the other from the hospital or facility where the work was performed. The pathologist's bill will cover his or her professional services in examining and analyzing your blood, cells, tissue, or

other speciments, reporting the findings, and consulting with your physician when it is appropriate. The bill from the hospital or other facility represents the cost of furnishing and equipping the laboratory and providing pathology services.

MEMORANDUM

DATE: March 21, 1989

TO: Albert E. Nelson

FROM: William B. Buckingham, M.D.

RE: Laboratory Billings from Pathology Providers Who Have not Actually Performed Professional Services

As a requirement of the Federal medical programs, including Medicare and Medicaid, the payment for professional services by pathologists or other hospital based specialists must be confined to payment for services actually rendered by that individual provider and at the request of the attending physician. Thus, if a pathologist performs a microscopic analysis of a biopsy or other surgical specimen and writes a report, a professional service has been performed and the pathologist is entitled to submit a fee which will be paid, again provided the attending physician has requested the pathologist to perform this professional service. This would also apply for the professional component for interpretation of electrocardiograms, echocardiagrams, electroencephalograms, flow studies, electromyographic and nerve conduction studies and other type studies in which it is necessary for a specialist to interpret the results of the special diagnostic and/or therapeutic procedure.

In the past, hospital pathologists have billed for a certain percentage of the total charge for certain laboratory procedures which are not actually physically performed by the pathologists. Specifically, this occurs in the automated chemistry field and automated blood counts where blood is drawn by a technician, entered into an automatic analysis device by another technician and a computer generated report is delivered to the hospital chart and/or the attending physician.

In this sequence of events, summarized immediately above, the pathologist does not perform any professional service on that patient. While the pathologists does, of course, perform some administrative service in terms of supervision, selection, assignment and training of personnel, etc., the Medicare and Medicaid programs have taken the position that this administrative function should be considered as a component of the "a" service, i.e., the service charged by the hospital for that particular laboratory service.

In keeping with established federal policy in both the Medicare and Medicaid programs, I believe that it would be incumbent on the Fund to pay for laboratory services which were performed by a professional specialist, either a pathologist or other hospital based specialist, where an actual service was performed such as in the surgical pathology and reading of tracings where the physician has a direct hands-on function and this results in generation of a report signed by that physician. However, I believe it would be inappropriate for the Fund to pay for a percentage of the total facility charge. Thus, when a hospital bills for an automated blood chemistry, blood count or other automated services in which no professional specialist has had a direct hands-on contact and no report signed by and generated by that professional person is involved, no fee for professional functions should be paid.

/s/ William B. Buckingham
WILLIAM B. BUCKINGHAM, M.D.
Medical Consultant

/ems

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

Case No. 92 C 4141
Judge Brian Barnett Duff

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND, MARION M. WINSTEAD, RAY CASH, R. JERRY COOK, HAROLD D. LEU, ROBERT J. BAKER, HOWARD MCDOUGALL, R. V. PULLIAM, SR., and ARTHUR H. BUNTE, JR., the present trustees,
Plaintiffs,

v.

PATHOLOGY LABORATORIES OF ARKANSAS, P.A.
Defendant.

STIPULATION CONCERNING THE AMOUNT OF REFUND SOUGHT BY PLAINTIFFS

This Stipulation Concerning the Amount of Refund Sought by the Plaintiffs is entered this 9th day of September, 1994 by and between counsel for the Plaintiffs Central States, Southeast and Southwest Areas Health and Welfare Fund, *et al.* ("Central States") and the Defendant Pathology Laboratories of Arkansas, P.A. ("Pathology Laboratories").

WHEREAS, Central States has made a claim for a refund of amounts which it asserts were mistakenly paid to Pathology Laboratories for claims denominated by Pathology Laboratories as the "professional component" of clinical laboratory services (the "Refund Claim");

WHEREAS, Pathology Laboratories denies any and all liability for Central States' Refund Claim;

WHEREAS, the parties intend to stipulate as to the amount of any payment to be awarded to Central States under its Refund Claim, such stipulation to be effective only in the event that the District Court finds that Pathology Laboratories is liable for the Refund Claim.

NOW, THEREFORE, the parties hereto, through their undersigned counsel, stipulate and agree as follows:

1. In the event the District Court finds that Pathology Laboratories is liable for the Refund Claim, then Central States is entitled to payment of $30,000, including accrued prejudgment interest as of August 31, 1994 in complete satisfaction of its Refund Claim, provided that any pre-judgment interest accrual after August 31, 1994 be calculated at one-half of the rates provided under 28 U.S.C. § 1961.

2. Pathology Laboratories reserves its right to consent on appeal any and all findings of the District Court in this matter, including any liability findings concerning the Refund Claim (except as to matters stipulated herein).

AGREED:

PLAINTIFFS CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND and MARION M. WINSTEAD, RAY CASH, R. JERRY COOK, HAROLD D. LEU, ROBERT J. BAKER, HOWARD MCDOUGALL, R. V. PULLIAM, SR., and ARTHUR H. BUNTE, JR., the present trustees,

By /s/ James P. Condon
JAMES P. CONDON
Central States,
Southeast & Southwest
Areas Health & Welfare
Fund
9377 W. Higgins Road
Rosemont, IL 60018
(708) 518-9800

AGREED:

DEFENDANT PATHOLOGY LABORATORIES OF ARKANSAS, P.A.

By /s/ Richard Raskin
RICHARD RASKIN
Sidley & Austin
One First National Plaza
Chicago, IL 60603
(312) 853-7000